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VOLUME IV

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The National Committee for Mental Hygiene

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The National Committee for Mental Hygiene and its affiliated state societies and committees are organized to work for the conservation of mental health; to help prevent nervous and mental disorders and mental defect; to help raise the standards of care and treatment for those suffering from any of these disorders or mental defect; to secure and disseminate reliable information on these subjects and also on mental factors involved in problems related to industry, education, delinquency, dependency, and the like; to aid ex-service men disabled in the war; to coöperate with federal, state, and local agencies and with officials and with public and private agencies whose work is in any way related to that of a society or committee for mental hygiene. Though methods vary, these organizations seek to accomplish their purposes by means of education, encouraging psychiatric social service, conducting surveys, promoting legislation, and through coöperation with the many agencies whose work touches at one point or another the field of mental hygiene.

When one considers the large groups of people who may be benefited by organized work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live happy and efficient lives.

QUARTERLY MAGAZINE
OF
THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.
50 UNION SQUARE, NEW YORK CITY

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The Indian Lake Reforestation Colony for mentally defective boys

MENTAL HYGIENE

VOL. IV JANUARY, 1920 No. 1

COLONY AND EXTRA-INSTITUTIONAL CARE FOR THE FEEBLEMINDED

CHARLES BERNSTEIN, M.D.
Superintendent, Rome State Custodial Asylum

IT is very noticeable that during the last decade the type of feebleminded that come to our doors for admission has greatly changed. Whereas ten years ago 80 per cent were idiots and imbeciles and only 20 per cent border-line cases or morons, now only 20 per cent are of the idiot and imbecile class and 80 per cent are morons or border-line cases. I believe that one reason why we are receiving so many more of these social misfits or failures is that machinery has to a great extent displaced common hand labor, and more highly organized society depends more upon coöperative activities, thus demanding more specialized ability of its individual constituents. It is our opinion that the time has come when something much less expensive and many times more wholesome and natural than the physical custody of brick walls and iron inclosures and large per capita expenditures for buildings and yearly maintenance is possible and practicable for a large majority of these cases—that many of them can be rehabilitated and saved for something better than lives of institutional servitude, by careful training in the kinds of work that they are capable of performing.

By conservative estimate, there are in New York State some 30,000 feebleminded and socially unfit in need of care and treatment, a heavy burden upon the state if they are all

to be maintained permanently in institutions. A system that renders a large percentage of them self-supporting, apart from the benefit to the individuals directly concerned, performs a threefold service: it relieves the state financially; it permits of increased facilities for the custodial care of the lower grades of feebleminded; and it adds to the community's supply of labor in fields in which the demand for workers is far in excess of the supply—namely, agriculture and domestic work.

The responsibility that rests upon us in this matter is further increased by the fact that we are receiving, not only a constantly growing number of border-line cases, but also many doubtful cases (under the law that allows us to take such cases for observation and study—Chapter 448 of Laws of 1912) in diagnosing which the best experts will differ as the case is seen from day to day. The one sure test as to the mental competency of such individuals to lead normal lives is, after thorough training, the world test. Many of them came from homes in which they have never known a normal family life, and many others have lived during childhood in great institutions, where little or no individual training, and especially no normal family domestic training, was available. The only fair treatment for these cases is to give them such training and then let them meet the test of life under favorable conditions in normal families, where they will have the benefit of the same kind of experience and the same kind of supervision and advice that go to the development of normal individuals. This is the method we are following in our boys' farm colonies, our working girls' colonies, and our parole system.

Boys' Farm Colonies*

Our first experiment in agricultural colonization was undertaken in 1906, when the Brush Farm Colony was established on a farm of 187 acres. On April 1, eight inmates from among our brighter boys, with a supervisor and assistant matron as farmer and wife, took possession of this farm, marching away from the old asylum premises, led by the patients' band, with

* We have not gone into the same detail in our account of our boys' colonies as we have in describing our colonies for working girls, as there appears to be little question regarding this procedure as applied to boys.

a team and large sleigh, two cows, one extra horse, a few cooking utensils, one month's supply of food, and the eight patients' clothing and trunks. The legislature of 1906 gave us $1,000 for furnishings, and with this money the house was made comfortable and tools were purchased for the farm. Four more boys were placed on the farm soon afterwards, making twelve boys there, and this number was later increased to twenty.

The financial statement of the colony for the first six months of its existence is of interest:

Credited with supplies to the amount of	$1,573.05	
Charged with supplies to the amount of		$904.26
Salary of farmer and wife		360.00
Profit to colony's credit		$308.79

Two years later we established a second colony—the Bailey Farm Colony, which also accommodates twenty boys and a farmer and wife. This was originally a farm of only fifteen acres, lying between the asylum farm and the first farm colony, but we divided the acreage of the Brush Farm with it, giving one hundred acres to each.

In 1910 another outlying farm, five miles from the asylum, was rented for $650.00 a year to be used for raising fodder and pasturage and for stabling our large herd of young stock. We have not, by the way, purchased a cow in twelve years, but have grown from our best calves the 160 cows we now have.

A fourth colony was started in 1912 on a neighboring farm of fifty acres, with accommodations for thirty boys, a gardener, and his wife. This colony supplies all the vegetables except potatoes needed for our family of from 2,200 to 1,950 inmates and 250 employees. In 1915 and 1916 we rented two good dairy farms—one of 270, the other of 200 acres—and placed thereon colonies of twenty inmates and dairies of forty milch cows each. These colonies produce milk for nearly all the butter that is needed in our regular dietary, in addition to producing all the milk needed.

A new experiment was tried in 1915, when we sent a group

of boys to the Adirondacks to do reforestation work for the Conservation Commission on the state preserves. This was planned as an economy for both the commission and the asylum. It furnished us with cheap beds and housing, and the commission with cheap labor, it being very hard to get labor in that remote district and very expensive to import it.

We had previously demonstrated that we could do this work successfully, having, under the supervision of the State Forestry Department, reforested forty acres of reverted state land, three miles south of Rome, and twenty acres of waste land on the asylum farm.

On October 1, a group of twenty-five boys, with two attendants and a representative of the Conservation Commission, were sent to North River in the region of Indian Lake. The tents and cooking utensils for the camp were supplied by the commission from stock kept for such purposes. The trees were grown in the commission's nursery at Saratoga.

By November 1, the boys had set out 150,000 trees, covering 150 acres, and the report made by the commission showed that this work was much better done than it ever had been by paid labor or convict labor. The work was worth about $1,000 to the state and actually cost us in direct expense about $400.00, $200.00 of which was for railroad fares, $100.00 for supplies, $75.00 for labor, and $25.00 for freight.

The success of this experiment led to the establishment of a permanent reforestation colony at Indian Lake. This colony is located on 150 acres of open farm land, where twenty boys live the year around and other boys come to camp in tents during the spring and fall planting seasons, the number depending on the number of trees available for planting. Fifty or sixty boys can do the house and farm work and plant 500,000 trees a year, in addition to caring for the nurseries which have been established on the farm for growing these trees from seedlings to the planting age of two years. On this farm the boys have produced all the vegetables, milk, butter, beef, pork, mutton, eggs, etc., needed for their maintenance and had excess products to sell. They have also been able to make extra money by working on neighboring farms.

Because of the high cost of materials and the difficulty of shipping them during war time, in the fall of 1918 we decided

to discontinue this Indian Lake Colony, intending to reopen it as soon as conditions proved favorable, as we have found this kind of work very beneficial to many of our boys. It is surprising to see how many of them are anxious to go to the camp and are glad to stay all winter, even though the place is so isolated. Indeed, the boys seem to glory in their isolation and in the fact that there is no one to interfere with them or irritate them and that they can practically have the run of things without being hindered or complained of by neighbors. A number of them, too, had opportunities to go out on surrounding farms to help cut wood, take care of stock, plant and harvest crops, etc., and several were placed on parole with farmers in the vicinity of the colony. Those of our boys who have incipient tuberculosis are greatly benefited by this open-air life in the Adirondacks, and while regaining their health, are made happy by being able to do a little work.

Another of our colonies—the Lawrence, opened in 1918—will be largely devoted to reforestation work. This colony is located on a 1,350 acre farm, with housing accommodations for forty boys. Only about 150 acres of it can be used for agricultural purposes; the rest is suitable only for reforestation. We are planning arrangements with the State Forestry Department to establish on this farm a permanent nursery for growing trees, both for the use of the Conservation Commission at other points and for our use in reforesting the 1,200 acres available on this farm and the thousands of acres of waste land on adjoining farms, so far as the owners of such land wish us to do this work. Our proposition is that we will reforest land for our neighbors on a share basis, the state furnishing the trees and the inmates of this institution—the state's wards—doing the work, and the state, at the end of a period of twenty-five or fifty years, taking a share of the timber product.

I believe that this is one of the largest and best pieces of work that we can do. It increases the value of the real estate, whether owned by the state or by private persons, and at the end of a few years the state reaps its reward both from increased products and increased taxes. In this way we shall be making valuable and productive much waste land that otherwise would lie idle indefinitely, especially while labor costs as it does these days.

A second boys' colony established during 1918 is on a small rented farm, about a mile away from the asylum, where we tried the experiment of caring for delinquent feebleminded boys under the colony system. We put in charge one of our experienced attendants who had managed what we call the "lock-up" group—that is, delinquent boys who have to be kept either in locked wards or in squads of from twenty to forty, under the constant supervision of two attendants, when working out of the wards. This attendant's wife acted as house mother.

The experiment has worked out very well. We were ourselves somewhat surprised to find how little trouble the boys gave, and we believe that this scheme might be carried out further with larger numbers of boys, though each of the groups must be kept small and considerably isolated. Moreover, we appreciate the fact that the success of such a colony depends entirely upon the ability of some one who is especially fitted and trained to manage boys.

Requests were received during the year from Warsaw, New York, and from Jefferson County near Mannville for farm colonies, the boys to help surrounding farmers, but for various reasons it did not seem desirable to establish such colonies at the present time.

The following table shows briefly the situation with regard to our boys' farm colonies at the present time:

Boys' Colonies	Opened	Acres	No. of beds	Cost
No. 1. Brush.	1906	187	20	Purchased, $10,000.
No. 2. Bailey.	1908	15	20	Purchased, $5,000.
No. 3. Rathbun.	1910	300	30	Rented, $600.
No. 4. Lamphere.	1912	50	30	Purchased, $5,000.
No. 5. Indian Lake. . . .	1915	150	20	Loaned by state.
No. 6. Stook.	1915	270	20	Rented, $1,000.
No. 7. Talcott.	1916	200	30	Rented, $1,000.
No. 8. Kossuth.	1917	.....	20	Rented, $480.
No. 9. Akron.	1917	60	40	Rented, $700.
No. 10. Dewey.	1918	90	20	Rented, $500.
No. 11. Lawrence.	1918	1,350	40	Rented, $600.
			290	

All these colonies are for agricultural purposes with the exception of Number 8, which is for boys at work in Rome

assisting in handling freight, caring for lawns, attending furnaces, shoveling snow, etc. All but Number 5—the Indian Lake Colony—and Number 9, which is in Erie County, twenty miles from Buffalo, are located within a mile or two of the city of Rome. These farm colonies, each accommodating at least twenty inmates, cost the state between $5,000 and $10,000 apiece, or a rental of from $600 to $1,000 a year apiece, whereas to build large brick buildings costs from $500 to $1,000 for every inmate. Moreover, these colonies, after the first year, are self-supporting, including all expenses and 5 per cent on the investment.

One of the plans that we have in mind is to colonize with morons abandoned or unoccupied farms such as are to be found on nearly every crossroad in every township. In addition to earning their livings on these farms and improving the land and buildings, the boys would have spare time to put in helping neighboring farmers—who are much in need of such labor—and thus further contribute to their own support. At odd times they could pick and crush stone and distribute it on the small crossroads that form the connecting links between the state-improved roads. When these abandoned farms, through good cultivation, became sufficiently valuable, they could be vacated as colonies and the increase in their value, gained through sale or otherwise, either revert to the state or be used for further colonization.

Working Girls' Colonies

Our first working girls' colony was opened in 1914. The following extracts from our annual reports give a good description of the purpose and methods of these colonies and the success that has attended them:

FIRST REPORT ON GIRLS' COLONIES

The following announcement was made at the opening of the first colony:

Rome, N. Y. October 7, 1914.

A working girls' home has been established at 209 West Thomas Street—telephone number, 172-J—where girls are available for domestic work, sewing, etc., by the day, week, or month. The girls going out from this place to work are capable of doing all kinds of domestic work, except special cooking. They are only able to do common cooking.

Their services may be secured by telephone. The rate is fifty cents per day, and their services will be available for employment at any time on short notice.

Settlement for services will be paid direct to the manager of the home. Bills will be regularly rendered weekly for such services.

These girls are not markedly defective, but are girls who have been orphans or have never known a normal home, and when later in life they have gone out into the world, they have been unable to get along because of lack of proper home training and normal worldly experience. As a result they were sent to this asylum for study, care, and training, and we are sending them out to work, after having been thoroughly trained and tested here, to see if they can get in touch with the world under normal conditions and thus learn to be self-sustaining and possibly have their entire freedom.

This colony is carried on in a rented house in the city, which constitutes the girls' home and social center, presided over by a housekeeper or matron, with a social visitor to inspect their working places and their street deportment, to accompany them to moving-picture shows and other social diversions, and to assist them in purchasing their clothing, etc. We hope in this way to have many of these girls learn through experience normal social reactions and family life, and thus to return the services of many of these willing and competent domestic workers to society and in this way lighten the load and make state care and supervision possible for all this class of dependents who positively need such care. Incidentally, in connection therewith we have established the most positive test possible as to the ability of some of these cases to rehabilitate or support themselves, regarding all of which we can never be positive in a considerable number of these border-line cases until such world test has actually been applied.

Of the sixty-seven girls who worked through this colony during the first year, forty-two remained at the end of the year, and twenty-five were returned as follows: nine for social offenses, such as flirting on the street, boisterous on the street, noisy at the colony, etc. (only two were really serious social failures); nine of the younger girls because they had not had sufficient training; and seven others because of sickness, or because their services were worth more to the institution than they were getting outside—namely, $3.50 a week—and they preferred to live and work at the asylum.

The very marked improvement occurring in these parole cases is most favorably commented on by all who come in contact with them, and there is no doubt but that it is just these normal experiences in life which these cases lacked in their earlier environment and the absence of which in their lives

during their habit-forming period was the real cause of their previous misfit or failure.

These girls served 226 families in Rome during the year. A number of the girls work one or two days a week at different places, about half of them having regular places where they stay continuously.

They earned $3,278.91, thus making themselves entirely self-supporting, with all bills paid and money in the bank to the colony's credit at the end of the year, as well as each girl, in addition to having paid for all her own clothing, having an individual savings-bank account. One girl had as much as fifty dollars in savings to her individual credit.

It required about one-third of the earnings of these girls to support the colony, including the cost of furnishings, rent, provision, etc.

Each girl is given twenty-five cents each week for spending money, and fifty cents cash each week for the savings bank. The remainder of all money collected is placed in the bank for general expenses, clothing, etc., and each girl is given money from the general fund for all necessary or reasonable purposes.

I do not hesitate to declare that the results of our year's experience amply justify us in deciding to go on with the work, and surely the general interest manifest in the experiment, if such it may be called, as indicated by the many letters of inquiry—among which may especially be mentioned those from the state boards of charities of Maine, Virginia, and Indiana, the State Department of Education of Connecticut, etc.—warrant the assumption that organized charity is awaiting avenues of social relief along these lines.

SECOND REPORT ON GIRLS' COLONIES

On September 1, 1916, a second girls' colony was opened in a large rented house, two city blocks removed from the first girls' colony, where ten girls between fourteen and sixteen years of age are to remain one year in home training before they go out to work, and thus, we hope, become even more efficient domestic workers. In addition to these ten younger girls, there are eight older working girls living at this colony, and a portion of their earnings, with a portion of the earnings

of the other colony, will be used to support this second colony and make possible this better training of ten of their younger sisters in need. Too, the older girls will be stimulated to set good examples to the younger girls, and the younger girls will be stimulated to do their best to hold their place and later to have the same chance the older girls are having, especially the larger freedom and finer clothes; the latter especially appeal to girls.

Night school has been established at the colony, where sewing, cooking, and book school are carried on, and we have been pleased as well as surprised to find the interest the girls manifest in these activities, even the girls who room and sleep where they work coming in for this work in preference to going to the movies.

Financial Statement, October 1, 1915 to October 1, 1916

Received from 247 customers		$5,418.82
Fifteen boys earned	$494.00	
Ninety-one girls earned	4,924.82	
		$5,418.82
Paid boys in cash, etc	$150.92	
Paid girls, cash, clothing, etc	3,173.64	
		$3,324.56
Fixtures and furnishings	569.67	
Expense (gas, water, phone, etc.)	229.47	
Rent	410.00	
Extra salaries	120.00	
		$1,329.14
		$4,653.70
Balance in bank		$765.12

Fifty girls have a total of over $1,000 in the savings bank to their individual credits.

	Colony	Institution
Number of girls passing through	91	
Number of girls paroled through	36	17
Number of girls discharged after parole	13	7
Number of girls discharged direct from	13	11
Number of girls returned from parole	14	6
Number of girls returned from discharge	3	2
Number of girls remaining on parole	9	4
Number of girls remaining in colonies	53	

Girls designated "institution" did not pass through colony training. About one-fourth of the girls go back and forth from the asylum to the city of Rome by bus, about one-fourth live at the colonies, and about one-half live where they work, thus making a sort of progression in their parole to larger freedom and responsibilities.

THIRD REPORT ON GIRLS' COLONIES

During the year [1917] two additional colonies have been established for girls, one at Westleigh, Staten Island, for girls at domestic work, and the other at Oriskany Falls, a colony for girls at work in a knitting mill. Requests were made for several additional colonies. However, we were unable to organize more this year because of lack of trained girls for the purpose who could be spared from our regular service, especially this year when so few good and reliable citizen employees are available for attendants and other regular service. Thus many of our most reliable boys and girls were pressed into service at the asylum instead of being given other privileges through colony life or parole. And here the question arises, is it fair and just to these boys and girls to deprive them of an opportunity to live outside the institution, so long as they are capable and trustworthy? However, we have not hesitated to do this in view of the pressing war emergency, just as soldiers are used everywhere under such exigencies.

Gloversville, Fort Plain, Fonda, Canajoharie, Hamilton, Oneida, Canastota, East Aurora, and Utica have all asked for girls' colonies, and several opportunities have presented themselves for other farm and industrial colonies for boys. Of course we require some little overhead capital to start boys' farm colonies—such as for implements, teams, seed, and fertilizer, as well as for house furniture—and thus, while we prefer to extend boys' colonies along agricultural lines, and scatter them about in sparsely settled communities, so that the boys' labor may be made available to assist as many farmers as possible, still it is much cheaper and more paying in immediate return, especially in these times, to start industrial colonies for both boys and girls to work in mills and at day's labor. However, it is our experience with these boys and girls, as with normals, that they have their preferences; some

boys like farm life best, while others like mill work, etc., and some girls like housework best, while others take to mill work or sewing or laundry work.

We believe that at the present time the largest and best outlet for girls' labor is hand sewing and hand laundry, and these lines of work are especially adaptable to colony life for a large number of girls who cannot be trusted so far as to go away from the colony for indefinite intervals, as is required where girls go out for housework.

The mill colonies, too, are especially well adapted to meet the requirements of a large number of girls who need continuous supervision, as the supervisor or attendant who goes to the mill with the girls acts as forewoman over them, and she can quickly learn the various operations and then act as instructor to the new girls as they enter upon the work; and herein again are the mill operators especially pleased with the arrangement.

Since October 1914—three years—200 girls have passed through the girls' colonies, and only 35 have been permanently returned, leaving 165 still out earning their own living. Of this number 77 have been paroled, and 63 discharged after parole, 14 still remaining on parole, and 88 remaining in the colonies.

Of course the greatest good in this colony activity, in addition to giving these girls larger opportunities for development, is that beds were made available for 165 additional girls, all of whom were greatly in need of such training and custody, and nearly every one of whom would otherwise have drifted further into crime and immorality and other troubles.

Number of girls passing through colony	200	
Number of girls paroled	77	
Number of girls discharged after parole	63	
Number of girls remaining in colonies	88	
Number of girls returned to asylum	35	
Number of girls cared for in colonies first year	67	(new) 67
Number of girls in colonies second year	91	(new) 45
Number of girls in colonies third year	96	(new) 69

The girls from the colonies are frequently met in groups and talked with about some of their failures or adverse experiences, as well as their exemplary experiences, so that all may

have the opportunity to profit through the mistakes as well as the successes of others, and it is really surprising to see how kindly they receive these suggestions and how hard they strive to meet the approbation of their supervisors and especially that of the superintendent. Individual evidences of more than ordinary success could be cited by the score where the girl in a household has especially and repeatedly exerted herself to please and even surprise "my lady," as they always designate the housewife for whom they are working. A girl goes and purchases fifteen cents worth of graham flour with her own money in order to surprise the family at breakfast with graham gems. Another tells the garbage man not to pound the can to loosen the frozen garbage, as she will get the teakettle of hot water to pour on the outside of the can to loosen it. Another asks the housewife if she can sit at her feet on the floor childlike and help her mend during the afternoon, rather than go out to the colony. Numbers ask to be allowed to take samples of their cakes and pastry to the superintendent, for him to sample and see how well they did.

To be sure, we did experience in the beginning attempts to discourage the project, such as a series of anonymous postcards sent to the women who were employing the girls, stating that they should be ashamed to employ scab labor, etc., all apparently from one source, a discharged and disgruntled former employee. Also, a group of boys attempted to molest and distract the girls on the street and loitered about the colony house, but the early coöperation of the police served to quiet all such disturbances.

We took the precaution of not starting out with definitely fixed or preconceived rules of procedure which might hinder or be impractical for natural development, but rather preferred to develop as we proceeded in the work, allowing our experiences, and especially the results of our conferences with the girls, to serve as suggestions rather than rules for future conduct.

We began with each girl so far as possible a new life and thus preferred that those who were to meet and work with them through the colony should have no basis for a biased judgment against them. We therefore decided that the colony officials should know nothing definitely of the girls' past

history, giving each girl the best chance possible to bury her past if she were so disposed; and one need but see the letters of advice that some of the girls write back to their girl friends remaining in the asylum to appreciate that at least some of them do attempt to bury the past and come to learn that goodness and virtue are their own reward.

As regards the benefit to each individual inmate under such a scheme of colonization as herein outlined there can be no reasonable doubt after an observation of the results of the work, and while some extremely technical and pessimistic observer might find a few startling exceptions to this statement, still a few failures are to be expected in almost any line of endeavor, and when they do not exceed 2 per cent of the cases handled, we certainly should not let these few failures be the sole guide to our future work in the care and treatment of the other 98 per cent; not even should the failures reach a percentage of 10—which they never have—should the result influence us too much in our work with the remaining 90 per cent.

Additional Girls' Colonies Opened

In view of the success of the girls' colonies already established and the growing demand for them from various communities, we decided to open two new ones during the past year (1918). One—opened July 1—was at East Aurora, where a matron and twenty girls were placed in a house with a monthly rental of $40.00. This has been the most immediately successful of any of the colonies that we have established. From the very beginning, it has been almost entirely self-supporting, paying all its own bills and having very few supplies sent to it from Rome. As a rule, it has taken us from six months to a year to get a colony on such a paying basis, but because of favorable circumstances, the demand for labor being great in the summer of 1918, the girls found ready employment without loss of the time usually spent in introducing the proposition to the community. While these girls have been able to place very little money in the savings bank, because of the high cost of all commodities, they are a most happy group and none of them would think of coming back to the asylum to live.

In the same month we opened a colony at Syracuse, where

we were able to take over a property with accommodations for from forty to sixty beds, formerly the Syracuse Shelter for Unprotected Girls. Because of the modern system of probation and parole in the juvenile and municipal courts, which tends to save nearly all the normal girls from reformatory terms, leaving only the abnormal to be placed in such reformatories and shelters, we were able to get this property at the very reasonable rental of $100 a month, including complete furnishings. It includes a chapel, a gymnasium, a department for adults and a separate department for younger girls, and large yards, and is certainly very desirable for our purposes, with the possible objection that it is too large and too much like an institution to constitute an ideal colony home. However, it is well situated in the center of a prosperous development section in Syracuse, where new homes are being built by well-to-do families, which means plenty of work nearby for the girls. Also, the project has the backing of many influential women in Syracuse who contributed toward the property with the idea that it was to be used for the care of friendless girls and who are glad to see it devoted to a like purpose. They feel that this colonization of high-grade feebleminded and border-line girls is really a continuation of the work that they had been carrying on for some years without recognizing a number of their girls as actually of this class.

The property, with furnishings, is valued at $40,000 and we were given the option of purchasing it for $30,000. The annual rental of $1,200 is to be continued at our option, also.

The Shelter formerly had bars on the windows. These have been taken off, and some of the high board fences surrounding the property have been removed. This has pleased the people in the neighborhood, as it makes the place look less like a prison.

This colony, too, started out under very favorable conditions, but an outbreak of influenza resulted in the non-employment of most of the girls for nearly two months, which greatly cut into our income. However, conditions soon returned to normal, and we are now receiving sufficient income to put money away in the bank.

It is interesting to note that in the case of both of these colonies—East Aurora and Syracuse—no one objects to the

presence of the girls and every one is favorably impressed and anxious to see the project succeed. This is true not only of the people who employ the girls. Many others are interested in seeing the movement carried on, especially those who have had a chance to see the improvement that takes place in the girls as a result of the larger opportunity for individual development which the colony affords and which the institution could not possibly provide; nor could any system of parole provide it without the colony as a social center for the girls and a protecting influence over them.

The Syracuse colony took the place of the one on Staten Island, which we decided to close. The experiment of conducting such a colony at a considerable distance from the institution—about 250 miles—had been carried on for a year and had proven the plan entirely practicable and satisfactory. But labor and food conditions becoming somewhat difficult because of the war, we thought it best to remove this colony to some place nearer Rome, where the exchange of help, inmates, and food supplies could be managed at less expense.

The closing of this colony met with considerable protest from the people who were employing the girls, they feeling that they were being deprived of a very great accommodation and convenience. Many of the girls, too, who were working through the colony felt that they would rather stay at Staten Island among the friends that they had made than return to Rome or go to a strange colony.

The list of our girls' colonies is as follows:

Girls' Colonies	Opened	No. of beds	Cost		Kind of Colony
No. 1. Evans (Closed 1919)....	1914	14	Rented,	$420.	Domestic
No. 2. Mason.....	1916	18	Rented,	$600.	Domestic
No. 3. Staten Is. (Closed 1918)	1917	10	Rented,	$480.	Domestic
No. 4. Parry.....	1917	18	Rented,	$480.	Domestic
No. 5. Oriskany Falls.....	1917	24	Rented,	$480.	Mill
No. 6. East Aurora.....	1918	20	Rented,	$480.	Domestic
No. 7. Syracuse.....	1918	40	Rented,	$1,200.	Domestic
No. 8. Robinson.....	1918	20	Rented,	$480.	Domestic
No. 9. Richfield Springs.....	1919	24	Rented,	$480.	Mill
No. 10. Hamilton.....	1919	20	Rented,	$300.	Domestic

These girls' colonies are all located in the city of Rome except Number 3, at West New Brighton, Staten Island,

Starting bag and baggage for the first farm colony

The Brush Farm Colony, the first boys' colony established by the Rome Institution

The second farm colony, the Bailey

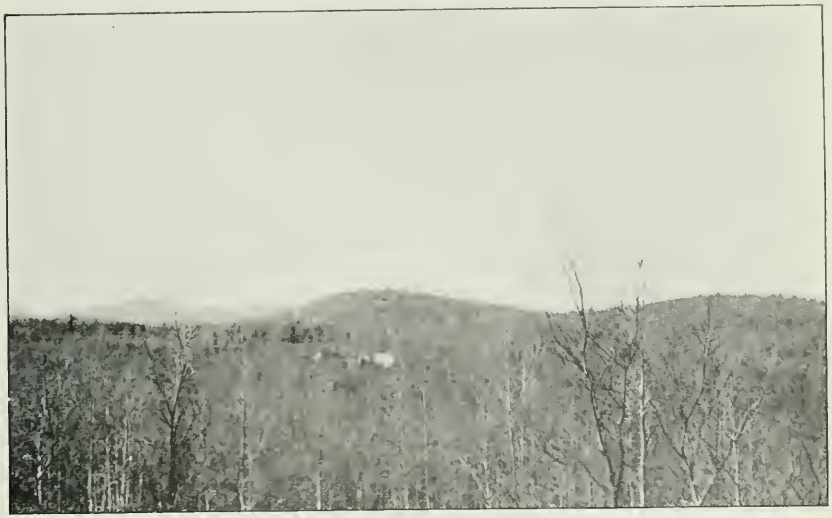
The fourth farm colony, the Lamphere, which produces all the vegetables except potatoes used by the institution

The fifth farm colony, the Stook, which supplies milk for a large part of the institution's butter

The sixth farm colony, the Talcott, used for growing young stock and beef

The Kossuth Boys' Colony, for boys working about the city of Rome

The camp colony at Indian Lake, for boys doing reforestation work



A view of the Indian Lake Camp, showing land to be reforested

A nearer view of the camp

Visitors at camp on Sunday

A prize tree planter. This mentally defective boy won the medal of the American Forestry Association. Land to be reforested all about.

While reforesting, the boys can produce nearly enough food on their 150 acre farm to maintain themselves, and in addition thereto plant one-half million trees per year (500 acres). This labor will be worth $4,000 to the state, including the care of the nursery. In fact it would actually cost more than this to pay for the work were civilian labor used.

Boys cutting wood at the Indian Lake Colony

Girls setting out from the institution to work in Rome

The first girls' colony, the Evans, for girls doing domestic work in Rome

The second working girls' colony, the Mason, which accommodates eight working girls and ten younger girls in training

Younger girls in training at the Mason Working Girls' Colony in Rome

The Parry Girls' Colony in Rome

The East Aurora Girls' Colony

The Oriskany Falls Girls' Colony, for girls at work in the knitting mill

A group of the girls in the Oriskany Falls Colony

A girls' colony birthday party on the lawn of a colony home

The Junior Boy Scout Organization of the institution resting from a hike

Paroled boys picking hops

N. Y.; Number 6, at East Aurora, N. Y.; Number 7, at Syracuse, N. Y.; Number 10, at Hamilton, N. Y. (for colored girls at domestic work); Number 5, at Oriskany Falls, N. Y.; and Number 9, at Richfield Springs, N. Y.

Each of the colonies for girls at domestic work really cares for and oversees a larger number of girls than the bed capacity of the colony indicates, as a number of the more trustworthy girls, after a few weeks or months at the colony, are allowed to sleep at the homes where they are employed. They must, however, report to their home colony at stated intervals, as well as generally for social diversions, special directions, etc. That is, the colony house serves as a home and social center for all.

The girls' wages have now been increased to $1.50 per day, or $5.00 by the week, and they are allowed fifty cents a week for spending money. The remainder of the earnings of each colony are placed in a general fund, from which supplies, clothing, etc., are purchased, each girl being charged with her personal clothing and other expenses. A complete individual account is kept for each girl.

The situation, put briefly, is this: On October 1, 1914, we had 450 girls in this institution. Between that time and July 1, 1919, we have admitted 675, making a total of 1,125 girls cared for, of which number 362 have passed through the colonies; that is, practically one-third of all the cases cared for and admitted since October 1, 1914, have received colony training and treatment. Of this number 225 have never had to be returned to the institution—that is, have clean records—which is 20 per cent of all the cases cared for during those five years. This proves the truth of the statement that I have been making for the past year or two—that from one-third to one-fourth of all the cases we deal with are adapted to colony life; for while only one-fifth of all the cases have proven successful at the first trial, still the records show that 131 of the cases were tried again and that finally only 28 had to be returned permanently for discipline. Actually over one-quarter of all the cases cared for since October 1, 1914, are still cared for outside of the institution—that is, are not occupying $1,000 beds in the institution.

The financial statement of the girls' colonies from July 1,

1918, to July 1, 1919, is the best proof of their success from that point of view.

Financial Statement of Girls' Colonies
July 1, 1918—July 1, 1919

Colony	Earnings	Paid Girls from Earnings	Operating Expenses Paid from Earnings	Operating Expenses Paid by State
Rome Group	$7,300.70	$4,198.35	$3,293.94	$5,118.45
Oriskany Falls	9,154.23	3,832.41	5,276.39	94.84
East Aurora	4,337.16	1,155.14	2,695.81	672.86
Syracuse	3,311.87	980.56	2,338.44	2,493.33
	$24,103.96	$10,166.46	$13,604.58	$8,379.48
Salaries				3,620.52
In round numbers....	$24,000.00	$12,000.00	$12,000.00	$12,000.00

The average earnings of 140 girls (the average number of girls in the colonies) were $165 each for the year.

The cost to the state was an average of $85 (supplies $60 and salaries $25) per girl per year, whereas it cost $280 for each girl at the institution.

A daily average of 140 working girls,* distributed among six colonies—three domestic colonies in Rome, one domestic colony each in Syracuse and East Aurora, and a mill colony in Oriskany Falls—earned last year $24,000. One-half, or $12,000, of these earnings was used for personal expenses and savings for the girls, and the other half for colony operating expenses, while the state expended an equal amount—$12,000—to supplement operating expenses. Thus, the support of these girls actually cost the state $85 per girl per year, whereas the per capita cost at the institution was $280 for the same period. Of course, the support of these working girls at the institution would actually cost less than the average yearly cost, as they would all be workers and contributors to the general household economy and would not require the expense of special school training or medical attention. On the other hand, they would require more expensive clothing than the average girl inmates in the institution, and, too, a house and bed, the cost of which does not appear in the per capita cost of $280; whereas in the colonies they not only paid for their

* There were as many as 160 girls at times in colonies, in addition to from 16 to 20 younger girls in training in junior colonies, maintained by the earning colonies.

own homes and beds in rental, but also contributed home, bed, and board for from sixteen to twenty younger non-earning girls.

The $12,000 used by the girls for personal expenses, savings, etc., represents the privileges and comforts offered to the colony girls by this freer life, such as free spending money, better clothes, church and social privileges, savings in the bank, etc.

Girls Passed Through Colonies October 1, 1914 to July 1, 1919

Discipline	
Total number passed through colonies	362
Number never returned for discipline	225
Number returned for discipline and tried again	131
Number returned permanently for discipline	28
Number returned permanently for incompetency or ill health	55
Parole	
Number paroled through colonies	136
Discharge	
Number discharged on good record	61
Number discharged as runaways	22
Runaways	
Number runaways from colonies 30, from parole 22	52
Number runaways discharged (including married, paroled, or lost)	22
Number of runaways returned	30
Number of runaways married—colonies	3
Number of runaways married—parole	7
Number of runaways immoral—colonies	7
Number of runaways immoral—parole	4
Number of runaways lost—colonies	2
Number of runaways lost—parole	5
Children	
Number of babies born to colony girls	0
Number of babies born to parole girls	9
Of the 9 babies born to parole girls:	
Mothers discharged—married	3
Babies born in institution (3 died)	5
Babies born outside and adopted	1

Parole Cases

Under the law of 1912 which provides that paroles may be granted to inmates to test their ability to live outside the institution, we have paroled 240 girls and 276 boys. Our

parole system is closely connected with our colony system, the colony serving as a step in the progression to larger freedom and larger responsibilities. Before we adopted the colony plan, many boys and girls who went out on parole became lonely and homesick and longed for association with friends and acquaintances; and when their work was done, rather than remain alone, they would tend to drift to the streets and associate with whomever they met there. Naturally, under these conditions, they either made undesirable acquaintances or became so homesick that they begged to be allowed to return to the institution, or actually did return of their own accord, having no friends or relatives to whom to go. This experience was one of the reasons that led us to adopt the colony plan, to help these cases gradually get back into touch with the world and learn the ways of the world and how to care for themselves, and at the same time to give them some place that they can call home while they are making their new associations and friendships, thus protecting them from unprincipled people and bad companions during their rehabilitation period.

The employment of a full-time parole agent to investigate homes and supervise the parole of girls, including the girls in the out-of-town colonies, has been a most helpful measure, and has served to relieve the superintendent considerably of all this detail, as well as making it possible to supervise and direct these girls more closely. We consider all the boys and girls in out-lying colonies as on parole, even though they are under the care of an employee of the institution, who lives with them as supervisor or house matron.

REGULATIONS GOVERNING PAROLE

The regulations that govern parole cases are as follows:

1. Application in writing shall be made to the superintendent by the person wishing to take an inmate on parole, and the home wherein such inmate is to be placed shall be investigated by the superintendent or his agent.

2. The person taking an inmate on parole shall sign an agreement in duplicate, one copy of which shall be filed at the asylum and the other given to the person taking the inmate.

3. Females shall not be paroled into homes such as public

places, hotels, boarding houses, hospitals, or places where there are transient or frequently changing residents or population.

4. The superintendent shall report to the board of managers at each monthly meeting the names of all inmates placed on parole during the past month, and the names and addresses of the persons in whose homes such inmates have been placed.

Form of Agreement for Boys

I hereby agree to take.....to live with and work for me with the understanding that after he has been with me four weeks, I will decide whether or not he proves satisfactory.

I agree to pay him $..... per month, with board and lodging.

I agree to report at least once in three months on how the boy is getting along, and make complete settlement.

I will take receipts for all clothing bought for the boy, and keep close account of the spending money I give him, which is not to exceed 25 cents per week, or $1.00 at any one time, if he is going to town, and the balance due at the end of each quarter will be left at the asylum for the boy.

.....

.....

I agree to the above contract.....

Notice

Boys going out on parole are not allowed to smoke. If they have the habit before going out, they will be allowed to chew tobacco, but **under no conditions** will they be allowed to smoke.

Form of Agreement for Girls

I hereby agree to take ..... to work for me, with the understanding that after she has been with me four weeks I will decide whether or not she proves satisfactory, and I agree to pay her $3.50 per week.

I agree to report at least once in three months on how the girl is getting along and make complete settlement for her services. I will keep accurate account of all money given her, and take receipts for all clothing bought for her, and keep close track of the spending money I give her, which is not to exceed 25 cents a week for general spending money, or $1.00 at any one time for special occasions, and the balance of the money due her at the end of each quarter will be left at the asylum for the girl, the understanding being that it is to be placed in the savings bank to her individual credit.

.....

.....

Also, the following notices were sent out to the employers of boys and girls on parole:

FIRST NOTICE GIVEN TO EMPLOYERS

The boys and girls who are sent out from this institution to work in Rome, and on parole elsewhere, are boys and girls who have proven themselves trusty at this institution and pretty capable workers along the lines of general institution work, such as domestic work, farm and garden work, etc., and while we do not consider them expertly trained in these lines of work, we do consider them good helpers. Of course, they need a little supervision to direct them in their work, at least until they learn to do the work in the way in which their employer would like to have them do it. They also need supervision and direction in their social life and street deportment.

Our object in sending these boys and girls out is that they may learn to live outside in the world and become self-supporting and at the same time vacate beds at the institution for more needy cases, especially younger boys and girls who need the training which they can get in an institution of this character, and for whom there is no other place.

We feel that the training in normal home life and household work and outside responsibilities which these boys and girls will receive in this way is really worth more to them than the money payment which they receive, and it is for the above reason that we allow them to go out to work for the small pay asked, hoping that after they become competent trained helpers and have proven themselves trusty and worth more, for instance, after a year of such service and training, they will receive compensation equal to the value of the work they then perform.

Many of these boys and girls were taken by social workers from very bad homes, where poverty, alcoholism, and other vices and lack of parental care prevailed, and placed here or in other institutions or homes for care, training, and protection, or were finally sent to us for further care, study, and training, and we are now sending them out to receive their finishing training and the final world test as to their ability to make good.

SECOND NOTICE TO EMPLOYERS

Where girls are sent out on parole to work in families, we are very anxious that the woman of the family should treat these girls very much the same as she would treat her own girl as regards controlling them in their street deportment, in spending their money, buying clothing, attending church, and matters of this kind, remembering that while these girls are apparently full grown or large and of adult age, still their mentality is retarded or subnormal, as they usually have a mental age of about eight to ten years, and therefore we cannot expect them, at first at least, to use much better judgment regarding their street deportment and actions outside of the house than a girl of that age would use, even though they are able to do a great deal of work, etc., as a girl their size ordinarily would do.

This work they have learned to do by experience, watching and assisting older ones do it, but they have never had any special training in street deportment, spending money, etc., and thus they need special close watching, training, and opportunities for correct habit forming along these lines.

They should not be allowed to go to picture shows alone in the evening, or even in the afternoon very far away from home, or be allowed on the street alone in the evening or on Sundays.

You should not hesitate to make them mind just the same as you would your own girl of eight to ten years of age, and if they do not do this agreeably, or if they tend to lie and deceive you, you should let us know at the institution at once. We are trying to have these girls learn how to live outside decently, and be helpful, and it is with this in mind that we send them out in this way, but if they don't improve by the experience, or tend to grow worse, and also if they lie and try to deceive you, they should be returned to the institution at once for further discipline and training.

They should save at least one-half of the money which they earn, to place in the savings bank as per direction in the agreement which you have signed. They must mind, be orderly, respectful, and honest as long as they remain out, or otherwise be returned.

Observation Cases

The law of 1912 which permits us to take cases for observation, in order that a careful examination may be made of their mental condition, has resulted in our receiving a number of such cases.

	Boys	Girls
1912	..	1
1913	14	6
1914	14	5
1915	24	12
1916	14	13
1917	12	15
1918	15	41

Arrangements have been made whereby we receive observation cases from the reformatories and schools for delinquents in New York State; that is, before inmates are discharged from these reformatories or schools, they are sent to Rome and retained here for a time to test their mental capacity. If a case proves to be feebleminded, arrangements are made for commitment to Rome; or boys and girls who are well trained, and old enough to take up colony life, are within a short time placed under colony management to test their ability to lead such a life. Later, if it is desirable or possible, they are sent out on parole.

Cases have been accepted from the Hudson Training School for Girls, the Bedford Reformatory for Women, the Albion Reformatory for Women, and the Valatie State's Prison for Women, and we have arranged with the Prisons Department to test out in this way additional women, between the ages of twenty and forty, from the state's prisons, where there is a question whether or not the case is feebleminded. That is, before the woman's sentence expires, she may be paroled from the state's prison to Rome and kept here under observation for a short time. If it is decided that she is feebleminded and a proper case for institutional or colony care, she may be committed to Rome before the expiration of her prison term, and thus be kept in custody and prevented from further drifting into crime or immorality.

Summary

We have been carrying on colonization with the feebleminded for the past twelve years and have proved it practical, economical, and feasible in every way.

We have at present ten farm colonies for boys, with at least twenty inmates and farmer and wife on each, living comfortably in the old farmhouse on one hundred or more acres of land. Such farms cost the state between $5,000 and $10,000 each, or a rental of from $600 to $1,000 a year, while institutional buildings cost at least $500 to $1,000 for each inmate. Also, these colonies are self-supporting after the first year, including all expenses and 5 per cent on the investment.

We have one colony for boys at work in Rome, such work including gardening, caring for lawns, shoveling snow, tending furnaces, etc.

We have eight colonies for girls in rented houses in the city of Rome and elsewhere about the state, where from 160 to 250 girls, under the supervision of matrons and parole agents, are supporting themselves doing domestic work, hand laundry, sewing, and mill work.

The purpose of these colonies is to test out the boys and girls in an existence more nearly normal than is possible in a large institution. The privilege of colony life is given only to self-respecting boys and girls of reasonable intelligence, who wish to make an effort to be self-sustaining, law-abiding citizens. The boys' ages run from sixteen to thirty years, the girls' from sixteen to forty; in the girls' colony for preparatory training, from twelve to sixteen years.

These boys and girls at first live in the colony houses, going out to work by the day. Later, if proven trustworthy, they are allowed to live at the houses where they work, using the colony houses as social centers for their leisure hours. Both boys and girls living in the colonies are encouraged to come back to the parent institution for dances, band concerts, moving-picture entertainments, and any needed medical attention.

Church and Sunday-school privileges are allowed to all who care to take advantage of them. For the girls, classes are provided in the domestic arts, mending, letter writing, etc.

Pianos and Victrolas are in use in all the houses, and girls who show ability are given musical instruction.

The colony houses and their activities are regularly inspected by a parole agent, who also visits the houses in which the colony boys and girls are employed.

Earnings are spent for housing, clothing, and savings-bank accounts, and—to the extent of fifty cents a week—for pleasures and personal expenditures. About one-third of the earnings go into savings, thus encouraging each individual in habits of thrift.

The results of the colony system we have found to be more self-respect, more hope, more happiness for individuals, and for the institution an atmosphere of hope that stimulates energy and industry, lessening the number of discipline cases.

If there was any lack of proof that our system, as devised and carried out, is practicable and workable, it was to be found in the fact that during my absence of two months at the Plattsburg Officers' Training Camp, in the summer of 1918, two new colonies for girls—the one at East Aurora and the one at Syracuse—and one new farm colony for boys—the Lawrence Farm Colony—which had been opened just before I went away and had not been thoroughly organized, went on successfully to complete organization without my having to lend a hand or advise in any way.

Conclusions

1. We believe that with better facilities for manual, industrial, and vocational training in our public-school system, to make up for the lack of opportunities for physical development, home training, and apprenticeship such as existed in the past, many of the border-line cases will be saved in community life and will never need asylum or custodial care.

2. From now on, we should devote our energies toward enlargement along the lines of colonization, to rehabilitate as far as possible the patients that come to us and to return their services to the state, thus vacating many of the beds in our existing institutions and making them available for younger and more socially dangerous cases.

3. The services of many of these women could well be utilized in large centers of population for domestic work, hand

laundry, and sewing, thus in no way materially competing with native or naturalized American labor. At least 20 per cent, and I believe 40 per cent, of all feebleminded and borderline cases can be very successfully and economically so handled.

4. There is ample opportunity for colonization of all the available trained men on various parcels of state-owned land and on abandoned or undeveloped farms, where such labor is especially needed. At the same time the individual is rendered happy, contented, and self-sustaining in an environment well suited to his mental state.

I am firmly of the belief that if this colony system is continued and proves as successful as it has in the past—which I am sure it will—we shall be able to provide in such colonies for at least one-half of all the feebleminded who will have to be cared for by the state of New York because of dependency or delinquency. This method of caring for them will save the state not only the hundreds of thousands of dollars that would otherwise be spent annually for the maintenance of these people, but also the overhead expense of $1,000 per bed for from fifteen to twenty thousand cases. If we only consider the interest on this investment at 5 per cent, it will mean a matter of a million dollars saved in interest on the twenty million that would be spent in building for these twenty thousand people.

And more, these cases will be made much happier and more contented by this method of treatment, much more normal in their lives and activities, while at the same time the public will have the benefit of labor which otherwise, according to present indications, will not be available.

In connection with such a colony system, many of the boys and girls who have proven to be entirely trustworthy and amenable to ordinary family life will be placed on parole—boys on farms and girls with good families—to the extent of some five thousand at least.

During the past ten years, I have seen many boys and girls thus rehabilitated, and the fact that a few fail on first trial or even repeatedly is no sure proof that we were mistaken in our judgment of their ability to live outside the institution. Often I have seen these failures succeed almost immediately

when placed in another environment, and continue to succeed from thence on; possibly the previous experience of failure was the best lesson they could have had. Most of us normal individuals have at one time or another been at the point of failure, and probably would have failed had indulgent parents and friends not given us a chance to try again and yet again until we eventually found ourselves. Nor should a small number of complete failures lead to the condemnation of a system that is proving successful in the great majority of cases, with benefit both to the individual and to society.

SOME NEW PROBLEMS FOR PSYCHIATRIC RESEARCH IN DELINQUENCY*

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IT is no longer necessary to dwell upon the value of careful psychiatric examinations of prisoners and persons accused of crime. Demonstrations made in this country during the last few years go far toward indicating that those disorders of conduct which we call crime and delinquency can be no more successfully managed without investigating the state of the organ of conduct than disorders of other kinds can be treated without understanding the processes responsible for them. First in the children's courts—from which lessons of even wider application may yet come—and later in nearly every kind of criminal-court procedure, psychiatric studies have come to be regarded by many judges as a routine part of judicial investigation. One has said that he would not continue his work "if he were deprived of the benefit of his psychiatric coadjutor." **

The extension of such work to correctional institutions was, in the beginning, solely for the purpose of detecting those individuals for whom we have more appropriate receptacles than prisons and reformatories, but, notably at Sing Sing Prison and the United States Disciplinary Barracks at Fort Leavenworth, systems of intra-institutional classification and management have grown up with the psychiatric study of prisoners as their corner stone.

Merely to give a partial list of the well-organized psychiatric clinics dealing with crime and delinquency that were in operation elsewhere than in children's courts when we entered the war will indicate the rapid growth of this new method of studying crime. The clinics of Fort Leavenworth, Sing Sing, the Police Department and the Department of Corrections in

* Read at the eleventh annual meeting of the American Institute of Criminal Law and Criminology, Boston, Mass., September 3, 1919.

** Quoted by Dr. Pearce Bailey in the *New Republic*, 1917.

New York City, the municipal courts in Boston and Chicago, the Bedford Reformatory, and the Westchester Department of Charities and Correction represented a field of useful, practical work almost co-extensive with types of our legal and institutional machinery for dealing with antisocial conduct.

Our entry into the war led to either the abrupt termination or the great curtailment of nearly all these clinics, for most of the psychiatric workers immediately entered the army or navy. In the army, fortunately, they found a fairly definite special service, and many of those who had been dealing with delinquency in the courts in civil life had opportunities to work along very much the same lines with military offenders. In the navy, although there was no specific psychiatric division, the services of medical officers with psychiatric training were utilized to some extent "at the mast" and in naval prisons.

I hope that I will be pardoned if I turn from my subject here for a few minutes to refer to a matter too important to pass over when military delinquency is mentioned. The discussion of court-martial procedure has filled many columns in the daily papers and pages in the *Congressional Record,* but so far there has been no reference to the adequacy of present methods of determining abnormal mental states in dealing with soldiers accused of crime. Legal procedures employed in trying and punishing men who come into conflict with military law have been discussed from many points of view, but, apparently, it has occurred to none of those interested to inquire whether any relations exist between the terrific experiences these soldiers have gone through and control over conduct, and to consider, if there are any such relations, whether present methods of administering military law take them sufficiently into account.

In spite of the examinations in the camps, the A. E. F. contained many men of less than normal intelligence or of unstable make-up, and those soldiers, like their comrades, were often exposed to almost unbelievable fatigue, to the effects of being knocked about by shell concussion, and to long-continued emotional strain. Any company commander who saw service in France will say that he did not hold his men—or even himself at all times—to the same standards of

accountability for impulsive words or acts under such conditions as in the cantonment at home. Allowances dictated by common sense were freely made by those who had to deal at first hand with men in these situations, but do our court-martial methods provide adequate safeguards for dealing with less obvious alterations in conduct dependent upon such new factors and for the more remote effects of stress?

Like every activity of the army, the administration of military law very properly concerns itself chiefly with conditions that exist during war. Is it not particularly appropriate, then, to take account of those extraordinary effects of modern war upon the human nervous system which in some of the armies in France were responsible for not less than 20 per cent of all discharges for disability? In England, when the frequency and importance of abnormal mental states among soldiers were brought strikingly to attention during the early days of the war, one of the first thoughts was the possible bearing of this new problem upon responsibility and punishment. The accusation that men with "shell shock" had been executed led to the statement by the government that a mental examination preceded not only execution, but trial in all serious cases. Is it not important that our own court-martial methods, not merely as laid down in regulations, but as actually applied, should be critically examined, in order that any defects which made it impossible to deal with such new situations in war should be corrected?

In a few months most of the civil activities interrupted by the war will be resumed. With the release from the military service of psychiatrists already experienced in this branch of applied psychiatry, and the acquisition of others trained during the war, it will be possible materially to extend such activities. It is highly desirable to make use of the new starting point thus afforded to review and evaluate what has already been accomplished and to direct attention to new and wider tasks for the future.

Time does not permit an extensive review here of the work of psychiatric clinics in courts and correctional institutions. Fortunately some of the most earnest workers in these clinics are also clear and forceful writers, and so we have excellent accounts of their methods and findings in the current litera-

ture.* It seems necessary, however, to sketch the general situation that existed when work was interrupted in 1917 before considering certain new fields for research to which I desire especially to invite your attention to-day. The clinics then existing could be divided, with a few exceptions, into two distinct groups, each performing quite different functions. Those in one of these groups, of which the clinic at Sing Sing Prison was perhaps the best example, had for their chief object rendering aid in dealing with offenders who had been convicted and were undergoing sentences. The question whether such persons should be temporarily separated from society or not had already been decided. The only issues that could be affected by the findings of the psychiatrists were the kind of institution in which confinement should be spent, the type of intra-institutional management most likely to be successful, the advantage or disadvantage of parole, and, when the needed special institutions existed, the transfer of mentally defective and frankly insane prisoners to more appropriate places.

Perhaps the most valuable service that the psychiatric clinics were able to render was aid in the management of individuals presenting special difficulties. In many instances, especially among older men, little change in management was likely to be made even when the existence of definite psychopathological conditions was determined. The life histories of such prisoners—who would be called "chronic and unrecoverable" if the terminology of medicine were employed—showed, however, so many opportunities for favorable modifications of events had their mental difficulties been known and dealt with earlier in life that a new system of classification based upon psychiatric study came out of their examination. The adoption of this system came from a determination that a similar study of the inmates of our prisons twenty years hence should not show such terrible results of failure to recognize and deal with easily manageable elements in human behavior. The state of New York is now committed to the adoption of a plan whereby the subsequent management of new prisoners received will depend chiefly upon the findings of psychiatric, social, and economic studies made in a central

* See bibliography, 1914-1919, at end of article.

reception prison to which all must be committed.* The same plan determines the future of soldiers committed to the Disciplinary Barracks at Fort Leavenworth, but with extraordinary opportunities for parole and commutation of sentences. The work of institutional psychiatric clinics has also brought out a mass of most useful social information regarding prisoners merely through the application of the methods of examination employed in the study of psychiatric cases elsewhere. Such clinics are distinctly arms of the correctional service. It is believed that they are indispensable in modern penology and that their wide extension is very certain to occur.

The other group of clinics existing when we entered the war was that attached to courts. Although the children's courts offered the first welcome to psychiatric clinics, municipal courts followed their example, and one of the most recent judicial organizations to avail itself of such aid is a court of domestic relations. Why supreme courts and courts of general sessions content themselves with the so-called medico-legal testimony of "alienists" employed by the district attorney and the defense—which is usually neither medical nor legal—remains a mystery. The findings of a psychiatric clinic, scientifically and impartially conducted with the sole purpose of aiding the judges in disposing of the human issues before them, have more practical value than all the "expert" testimony that either side could purchase with the proceeds of a Liberty Loan.

It would be entirely logical from a scientific point of view, but doubtless impractical because of the gulf that exists between courts and prisons, to effect some practical kind of liaison between psychiatric clinics in classification prisons and reformatories and those in the magistrates' and higher criminal courts. To the medical mind, one typifies the hospital and the other its outpost, the dispensary. Such an arrangement, in the case of correctional institutions and courts, would render the psychiatric and social investigations made in one available in the other, and enable the same methods of treatment to be applied to the delinquent indi-

* Psychiatric Classification in Prison. By Hon. Lewis F. Pilcher. Publication No. 53, National Committee on Prisons and Prison Labor. New York, 1919.

vidual at many different steps in his career, much to his advantage and that of society. This being difficult or impossible, the best substitute is the adoption of uniform records and standards in examinations, constant interchange of reports and frequent conferences between the psychiatrists, psychologists, and social investigators working in the courts and their colleagues in the correctional institutions. In the work in criminology undertaken by the National Committee for Mental Hygiene with funds provided by the Rockefeller Foundation, an effort has been made to bring about effective integration by such means.

In addition to the clinics attached to courts and those in prisons and reformatories under way in 1917, there was another that occupied a unique place. This was the clinic which the insight of Arthur Woods into the real problem of the police caused to be established in connection with the New York City Police Department. As an aid to the police department, this clinic was a most successful enterprise. By talks and conferences, as well as by the actual work of the clinic, police officers were given a practical knowledge of mental factors in antisocial behavior that was of great value to them. As a result many defective or psychotic persons were put in the way of receiving supervision or treatment without the necessity of bringing them to the attention of the courts. If there is a gulf between the courts and correctional institutions, however, there is an ocean between police departments and courts, and this fact greatly interfered with the usefulness of the Police Department Psychiatric Clinic in New York City.

The activities that I have just enumerated form the material for the first chapter in the annals of psychiatric work in crime and delinquency in this country. It was natural that the original excursion of psychiatry in these new fields should be in the direction in which lay the most neglected tasks and the hope of most immediate practical returns. Such work must be continued, strengthened, and broadened in every way. In planning future work, however, the usefulness of that which has already been undertaken justifies taking up studies from which practical results may not always be so apparent or likely to follow so closely. It used to be said that research

must be done by stealth in a democracy. After the experience of the war, during which research into some most abstruse problems in chemistry, physiology, and physics went hand in hand with such eminently practical work as gassing, bombing, shelling, and bayoneting our enemies, it is no longer necessary for research to show itself in public only when concealed under academic robes. The young naval officer who has located a German submarine through methods of sound detection discovered in a college laboratory for the study of acoustics, and then has hopefully dropped an "ash can" over the stern of his vessel and observed the results, is no longer inclined to scoff at research. Without further justification of original psychiatric inquiry in the field of crime, let us consider a few problems for an attack upon which it would now seem that the time is ripe.

One of these problems deals with the study of certain mental mechanisms in relation to criminal behavior. Dr. Bernard Glueck has shown that a relatively small proportion of all the adults in a community contribute nearly all the criminals, and it is well-known that the same individuals, as recidivists, help to swell the censuses of many different kinds of correctional institutions at different periods in their lives. If we exclude those whose delinquency is secondary to and dependent upon quantitative defects in mental development or mental changes brought about by clearly recognizable disease, the number of persons to form material for such research as I have in mind is seen to be still smaller. We have now, regarding this inner group of delinquents, who come as near as any to representing crime in "pure culture," not a little information dealing with race, heredity, environmental influences, early conflicts with society, reactions to alcohol, sex life, and the effects of the different types of management employed when they first came to the attention of peace officers. But as yet we have only the most meager information regarding the interplay of impulses and inhibitions that makes up for them, as it does for the rest of us, the unending conflict of mental life, and the part played in antisocial conduct by personal complexes and rationalizations. We have at our disposal excellent methods of identifying the feebleminded, upon which we rely a good deal in the psychiatric examination of

prisoners, but we sometimes forget that feeblemindedness determines the sphere in which the activities of life will be carried on, while quite different factors chiefly control the nature of these activities. Some feebleminded persons manifest delinquent traits even before the effects of mismanaging their feeblemindedness have time to show themselves, while others, even under pretty inferior management, exhibit a strong tendency to docility, cheerfulness, and industry—the degree of intellectual defect being the same in both instances. Hence the importance of taking into account other factors than degree of intelligence in the study of criminal conduct.

If this is true even in the defective group, in which there would seem to be the least opportunity for such factors to exert their influence, it is not surprising that in those whose intelligence equals or is above the average level factors operating in the affective field usually outweigh even the powerful influences of environment or early experience, the antisocial trends that culminate in crime having their roots in difficulties of mental adaptation. Inquiries in this field take us far deeper than detecting mental deficiency, discovering psychotic trends, or outlining the main elements in personality. The day of studying human beings by *groups* has passed, but in this work it is not enough to study the *individual* as a whole. We must go into the life of the prisoner as minutely as the psychiatrist does into that of his patient, when searching for the mechanism of the neurosis or psychosis and for promising openings for treatment. The work of Dr. William Healy, in the study of such specific types of delinquent conduct as lying, making false accusations, and stealing, illustrates the difficulty of such research as well as the rewards to be gained. His patient analyses of his cases show mental conflicts that ordinarily would have been overlooked, exercising almost inexorable control over conduct, and lying quite beyond the reach of methods of management that often prove successful with other delinquent boys and girls.* We have only to consider how many of our own most important acts and decisions are determined by our complexes and rationalizations rather than by environmental pressure or

* See bibliography, 1914-1919, at end of article.

logical processes to realize that crime may often have a similar origin.

Recent progress in psychological medicine has provided us with new resources for the understanding of human behavior, not only in the mentally ill, in whom we psychiatrists are chiefly concerned because they are patients and we are physicians, but in those whose conduct differs so much from that approved by society that control of their acts has to be taken out of their hands and put into the hands of others. We must now commence to make full use of these new resources for research in the field of criminology and no longer content ourselves with performing certain immediately practical tasks in this work, while we reserve the most highly developed tools in our possession for those whose disorders of conduct the world has agreed to call illnesses.

The benefits to be expected from extending psychiatric research to the new fields which have been opened in correctional institutions and the courts are many. Enrichment of our knowledge of the springs of human behavior is one of these benefits, but I should like to invite attention especially to benefits likely to come to the delinquents themselves and, indirectly, to those who have the task of caring for them. Such studies as I have indicated show too often, when made with adult offenders, that the opportunity of modifying antisocial trends has already passed. The genesis in childhood of these trends that make shipwrecks of life is often clearly apparent, but usually it is equally apparent that efforts to unravel the tangled web are certain to be very difficult and likely to be fruitless. This is not always the case, however, even in that large group of persons who are called constitutional psychopaths because they have an undoubtedly constitutional tendency to react toward difficult situations in a neurotic or psychotic way or have defects in volition or emotional control which make adaptations that are very simple for others very difficult for them. Although there has been little opportunity in correctional institutions for the very careful study of individuals in this group, we must remember that all delinquents are not in prisons or reformatories. Wealth, social position, favorable environment, and wise relatives often prevent constitutionally psychopathic persons with very

delinquent tendencies from being dealt with by the criminal law. Like all psychiatrists, I have had a certain number of such cases brought to my attention. Some have been in private institutions during periods when their temporary seclusion seemed desirable, some were spending most of their lives in travel with highly paid, but rapidly aging attendants, and others were having their activities directed, with more or less success, to poultry-raising or sheep-growing in quiet and usually remote neighborhoods. Such resources help a few very inadequate persons to evade situations too difficult for them. There have been several instances, however, in which I have seen most satisfactory results follow careful psychiatric study of the problem presented by such persons and skillful, well-directed efforts to aid them in finding a better solution for their personal difficulties than that which they had found for themselves with help only when there were consequences to be averted.

In such cases one finds sometimes that the most difficult therapeutic problem is the habit of delinquency rather than the deep-lying causes of antisocial conduct. Being a delinquent person is nearly as bad for a constitutionally psychopathic individual as having the inadequate make-up that leads to delinquency. This points strongly, of course, to the importance of dealing with such individuals early in life when, even if it has been impossible to intervene in time to prevent the first departures from acceptable conduct, there is yet time to prevent such reactions from becoming habitual and to find out what the real difficulties are and to try to devise a solution for them. Thus far the children's court is the outpost in the psychiatric study of delinquency, but this winter a study is to be undertaken in a resident school for truant children who have not yet presented other evidences of delinquency. It is intended to approach the problem presented by these children, whose very earliest contact with organized society resulted in disaster, from the point of view of research, at the same time making use of any openings for treatment that appear. The number of individuals thus studied will not be impressive, but the problem presented by each one will be examined by the methods used in the most painstaking clinical and social work.

Without halting in the least in the pursuit of the psychiatric studies in criminology that were being commenced under such good auspices in courts and correctional institutions before the war and are now being resumed with new energy, it seems essential that a few centers like the Judge Baker Foundation in Boston should be provided, where research can be undertaken in such directions as the one that I have very briefly outlined. We must not content ourselves with cataloguing and classifying the delinquents with whom we are permitted to work in these new fields and, above all, we must especially guard against the danger of permitting ourselves to be influenced too much by the use of terms that suggest hopelessness in management. Often the therapeutic picture is dark enough, but a little more knowledge brightens dark pictures in criminology as it so often does in clinical medicine. Names with a fatal or hopeless significance have a tendency to stick long after advances in science have rendered them inappropriate. We must remember that the application of psychiatrical knowledge to crime and delinquency is now in about the same stage, chronologically, as the application of medical knowledge to the study of mental diseases was in the days of Philippe Pinel.

The results of work under way will be increasingly valuable as it spreads and becomes better organized, coördinated, and, in some respects, standardized. I believe that existing systems of dealing with prisoners, especially first offenders, will soon be greatly altered by the findings of these clinics. It is, however, important not to stop there, but to organize in a few selected centers psychiatric research into crime and delinquency, not only as an aid to courts and prisons, but as part of the general advance of psychiatry. Such research should be undertaken to prove no thesis. It should be directed by those who have no propaganda to spread, not even that for prison reform, however much the management of prisoners may ultimately be modified by results. It should be animated by the spirit of original investigation that approaches new ground with clear vision and an impartial mind, but is ever awake to the possibility of utilizing its findings for the betterment of mankind. Knowledge that was learned at the bedsides of the insane has been usefully applied to practical tasks

in criminology. I venture to predict that new knowledge gained in the study of abnormal human conduct in prisons will extend the frontiers of psychological medicine and some day, perhaps, repay the debt which the medical criminologist owes to the clinical psychiatrist.

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THE MOVEMENT FOR A MENTAL HYGIENE OF INDUSTRY *

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I purpose to set forth, all too briefly, the main outlines of the movement now taking shape for the mental hygiene of industry. I want to speak primarily to the employment managers and other industrial executives interested in personnel. I want to address the employment managers particularly, not because they are more interested in the personnel problem than anybody else—for example, housewives, public officials, civil-service agents—but because the modern group of employment managers is very much alive to the new work in personnel and yet stands a little confused before the many voices on the public platform, in the trade journals, and in their own executive offices. I want to propose the term "mental hygiene of industry" for a rapidly growing group of ideas suggested by such phrases as the following: *the human element, personal factors, individualization, character analysis, scientific selection, social significance, moral values, workman's standpoint, workman's ambition, creative impulse, instinct of workmanship, rôle of habit, fatigue and efficiency, antisocial behavior, wasteful emotions, unemployment and personality, the psychopathic employee, civilian shell-shock analogues, neurasthenia a disease in engineers.* All these terms and many others like them have been found in the recent engineering literature, to which an increasing number of articles are now being contributed both by practical managers who have grown up in the work and by specialists from many fields who have been called in, each to give his mite toward the solution of the industrial problem. For all these considerations, the term "mental hygiene," now proposed, is likely to gain adherents from every side. The term seems a good one in itself, and it has become familiar to modern

* Preliminary report of a research being conducted under the auspices of the Engineering Foundation of New York.

workers on account of the excellent results obtained in various fields in war and peace by the National Committee for Mental Hygiene, founded in 1909. The term has the special advantage of not assigning the so-called human element to any one particular science or art, such as psychology, psychiatry, or social work. The psychologist, whether inside or outside of a laboratory, can readily claim and often does correctly claim that he is a mental hygienist. The psychiatrist, neurologist, or other specialist in nervous and mental disease can also properly term himself and often does term himself a mental hygienist. And the newly developed art of social work, particularly in its so-called psychiatric division, is month by month developing new workers who are very effective aids in mental hygiene. Also, the practical and intelligent employment managers of the present day, whether trained by experience alone or in the special courses recently established—and, of course, greatly stimulated by the war emergencies—are workers that also deserve the name mental hygienists.

Time was when the mental hygiene of industry was regarded as hopelessly vague, nay utopian. Of course the field of industrial hygiene itself has come under cultivation only recently. The world had become accustomed to the idea of public health, and it was only natural that the great conceptions of public health should begin to be applied to industry. Factories and mines began to lay their health problems at the door of public-health and other medical specialists. Meantime eager laboratory workers were more and more minded to carry their results from the test tube, the microscope, and the smoked drum back to the factories and mines. Yet always over and under and shooting all through these problems of factory and laboratory there was this so-called human element, baffling, but inviting, vague, but insistent.

Probably the war served to precipitate out of vagueness the mental hygiene of industry. In the war the psychologists got interesting results with their individual and group tests. At the same time, the specialists in nervous and mental diseases were showing concrete results in obtaining an army relatively free from liability to what, for want of a better name, has been called shell shock. Not the least achievement

in the mental hygiene of the war was the development of a small, but effective group of social workers as skilled as laymen can become skilled in the approach to mild mental and nervous diseases and their practical handling under medical direction outside institutions. When we use the term "mental hygiene of industry," we intend, therefore, very definitely to suggest that something practical in the shape of a new art has been found, looking toward betterment in industry. That the mental hygiene of industry will ever become a science in the sense of a body of rules susceptible of rigid application to all cases is nowhere asserted. Nor is it possible, I think, that mental hygiene will ever become a science, whether applied to public service, to private life, or to such community problems as industry. Some appearance of a science will probably loom up in some of the future applications of the art of mental hygiene to large-scale production in manufacturing, mining, and transportation. But I believe that mental hygiene will nevertheless remain an art, a practical aid to industry rather than a science of the rubber-stamp variety.

One word concerning the relation of the mental hygiene of industry to industrial hygiene in general. It is the community's good fortune that the modern big ideas of public health and preventive medicine have been applied to the enormous concerns of modern industry. Now comes the task of articulating the newer ideas in mental hygiene with the rest of the task. Had it not been for the war, this fusion of physical-health ideas and mental-health ideas for the betterment of industry might have been postponed a decade or a quarter of a century. So far as I can see, the workers in every field of war work, however practical in the old sense of that term, got a very good idea of the unexpected practicality of the various mental hygienists in war time, whether, as psychologists, they were "rating" officers or enlisted personnel; whether, as neuropsychiatrists, they were eliminating defectives and anticipating the shell-shock neuroses; or whether, as psychiatric social workers, they were aiding in the reconstruction of individuals or families and facilitating institutional adjustments. Yet I should not place too much emphasis on the war contribution. We can see in antebellum literature some most suggestive contributions to this topic.

Economists like Carleton Parker had already come to see the mental-hygienic side of industry. Specialists in government, like Mackenzie King, had developed ideas about industry and humanity that might properly be classed under mental hygiene.

One good way of finding out whether a science or an art is really something definite and not merely an empty logical fiction is to note whether the supposed science or art has itself developed a personnel. Let me briefly sum up the situation as follows:

(a) There is a *psychology of industry* because there are certain applied psychologists or "mental testers." This applied psychology uses mental tests and scales, after the manner of Binet and others. These tests and scales have been developed for individuals in groups and are susceptible of vast specialization, as industrial problems get definitely in mind. The mental tests seem to be especially useful in hiring. Perhaps they will become useful in the always difficult problem of promotion. Perhaps even some of the problems of job analysis for individual workmen will be solved by applied psychology.

(b) There is a *psychiatry of industry* because there are certain psychiatrists and neurologists who have actually been at work on the problems of industry. Its immediate value is likely to be in relation to the problems of discharge and in grievance problems, particularly if by the term "grievance" we could be understood to mean also all sorts of minor dissatisfactions in plant management. Industrial psychiatry is likely to be of especial value, it would seem, on some sides of the analysis of "turnover." Practical experience in getting jobs for the mentally handicapped unemployed seems to indicate that industrial psychiatry will be of special value in job selecting for certain psychopathic or cranky or "different" employees, whom it may be extremely desirable to retain in service. Experience in this field will eventually throw much light on the problems of hiring and promotion.

(c) There is a *field of psychiatric social work in industry* because there are psychiatric social workers now prepared to enter the field of industry. (A few individual workers have already entered the field, but too few from whom to draw

general conclusions.) Psychiatric social work is a new art, in part auxiliary to medicine, in part of independent scope. These workers track down the discharge, grievance, dissatisfaction, and psychopathy problems outside the factory or mine. They might help to track down these same problems inside the plant, on demand of employment managers or minor executives. The point of view combines "efficiency" and "welfare" and brings to the surface many stabilizing and destabilizing factors inside and outside the plant—factors that the managers have rarely seen till too late or perhaps in too general terms.

Concerning (a) the new *industrial psychology*, there is no doubt of its permanence. Early claims were no doubt too sweeping. But, though the professors were overenthusiastic, the industrialists were equally injudicious in their expectation of ready-made results and rubber-stamp devices for manipulating the human mind. A little perspective or ordinary business sense should have stopped such vagaries.

But the personnel work of the psychologists in the American army and the elimination, by neuropsychiatrists supported by psychologists, of the feebleminded from the army have settled for all time the question of the applicability of skilfully and specially devised mental tests to groups of men as well as to individual men. We do not need to concede one-half of the claims made for this work to concede that this kind of mental-measurement psychology has come to stay. Even if we limited consideration to the personnel work of the Secretary of War's office alone, or to the work of the nervous and mental division of the Surgeon General's office alone, we should be able to demonstrate the value of these methods. Of course it will be a long time before the full story of these efforts and results can be properly told by the experts engaged. But no one who aided in the unheroic, but strenuous "Battle of Washington," and saw on the ground the progress made possible by the above two agencies, can fail to see that a long step was there taken in military psychology. Here was large-scale production with a vengeance. It takes but half an eye to see that many of the methods and some of the conclusions of military psychology can be carried over with due modifications into industry. And in point of

fact some of the army psychologists are now entering the industrial field.

Concerning (b) *industrial psychiatry,* the situation is undeveloped, but hopeful. There are important lessons from the war here also. The Surgeon General's office had a busy and effective new division—new to any army, it is believed—called the Division of Neurology, Psychiatry, and Psychology. This combination of interests already constituted a long step in the direction of a true mental hygiene, containing specialists in abnormality and in normality of mind. To be sure, the sociological side of the problem was not adequately represented in the new division of the Surgeon General's office as it was constituted in the war, but that was no doubt due to the lack of practical sociologists interested in the relations of man to man, soldier to soldier. However, many of the psychiatrists and psychologists were sufficiently men of the world or socially minded so that a due admixture of the sociological point of view was almost attained. In the end, too, the establishment of the so-called "morale officers" shows very well the trend of the whole plan towards a consistent military mental hygiene, representing psychiatric, psychological, and sociological viewpoints.

If there was a military psychiatry entirely aside from the problems of the front—i. e., a military psychiatry due to the existence or the development of more or less mild and incapacitating nervous and mental diseases in American camps already on this side of the Atlantic—it is plain that an industrial psychiatry of similarly large dimensions must exist. Perhaps of larger dimensions! Women are engaged in industry. Older men and women are found in industry than the men of military ages. Industrial risks exist, perhaps not so acute as the war risks, but of a very varied nature.

Before the war the psychiatrist was almost unheard of in industry. Here and there some plant physician or accident specialist might be found who had had a partial training in nervous and mental disease. But, if his judgment was sharpened by that training, the fact was forgotten, and his success was no doubt laid to his "personality." Nowadays a few more men can be found associated with advanced plants. Yet in one plant system, where over twenty-five physicians

held posts for one purpose or another, it transpired that no single one of these physicians had ever had training in nervous and mental disease!

Nor can such men be easily obtained. He would be rash who would claim that there are two thousand trained male or female American neuropsychiatrists. Probably there are far less than one thousand able and willing to work in connection with industry. The majority of them are at work in other absorbing tasks. For some time it will be advisable for large-scale plants to have part-time consultants, chosen from amongst the more able mature neuropsychiatrists. Care must be exercised in the selection, for some of the professionally best of these men remain too analytic for the industrial situation and unable to see the values of rough-and-ready practical combinations which are the lot of employment managers and the minor executives. These consultants, if they once see the problem, can choose full-time younger medical aids, if such prove practically necessary.

As for (c) *psychiatric social work in industry,* we are entitled to expect large results therefrom. We have grounds of expectation, not only from war work, but also from the results obtained by psychiatric social workers long *ante bellum.*

Just as nobody would now think of denying the routine value of physicians and surgeons in industrial plants, so nobody can fail to note the good done by ordinary social workers in connection with industry. There is simply no dispute on either of these matters. To be sure, some managers may stress the *welfare* values of the doctor and the social worker, while other managements think of them as contributing to plant *efficiency.* But these are questions of the temperament of the managers, not of the nature of the results in the plants.

Now it requires no great refinement of viewpoint to see that, instead of a general practitioner of medicine, for some plant purposes—e. g., discharge, grievance, and certain turnover problems—a physician with psychiatric training would serve far better. The psychiatrist is by training and experience a *specialist in grievances;* why is it not logical to apply this specialization to the grievances of industrial plants? On

precisely the same grounds, the social worker *with psychiatric experience* is preferable to the general social worker for the purposes of industry if we can prove that a considerable number of the more difficult plant problems are psychiatric or have a psychiatric tinge.

For the present argument, may I take for granted that the values of psychiatric social workers *outside of industry*, both in war work and in peace work, are generally admitted? To be sure, there may not be over two hundred trained and experienced psychiatric social workers in the country at the present writing; accordingly it is only where they do exist or have been at work that their values are even understood, much less questioned. But there is, so far as I am aware, no dissentient word anywhere about the results of their work, where they are in evidence at all.

But we have stronger evidence. For about five years, the Psychopathic Hospital in Boston has carried on specific work in relation to the psychopathic employee.[1] Some studies of the results of this work have already been published. (I do not here refer to work on occupation neuroses[2] and upon the nervous and mental sides of industrial accidents, which topics have also been the subject of special communications, but rather to the topic of the psychopathic employee in a more general sense.) The fates of these psychopathic employees in and out of industry have been minutely followed by the psychiatric social workers of the hospital, some of whom have specialized in the problems of employment. Probably more minute work has been done upon this problem from the hospital side than by any other agency. For a large part of the five years in question, a special committee has been interested in the matter. As an outgrowth of this work, the Engineering Foundation of New York, administered under the United Engineering Society and other special engineering societies, has under way preliminary investigations on the topic.

We already know in specific instances what the psychopathic employee has cost the plant, the family, and the state.

1 See The Psychopathic Employee: A Problem of Industry. By Mary C. Jarrett. *Medicine and Surgery*, Vol. I, pp. 727-41, September, 1917.

2 See Occupation Neuroses. By E. E. Southard and K. C. Solomon, in "Diseases of Occupation and Vocational Hygiene," edited by George M. Kober, M.D. and William C. Hansom, M.D. Philadelphia: Blakiston and Co., 1916.

We have cases under care which might have figured in dozens and scores of "turnover" analyses in various firms, had such analyses been made. In one instance, five typewritten pages were occupied by the bare entries of employment and discharge by various firms. Of course our work was undertaken primarily in the interest of the individual patient and secondarily in the interest of saving the public service additional expenditures for unemployed psychopaths. We did not at first have in mind the efficiency or welfare of industrial plants. But it has now become perfectly plain that the interest of the community, broadly considered, is identical with the interest of industry more narrowly considered, and that both these interests are identical with the psychopath's own interest.

This is not the place to expound details of cases. In the spring of 1919 we were able to demonstrate, from the everyday material of the Psychopathic Hospital clinic, a number of things of great interest to employment managers sent to us for practical exercises. We showed man after man whom the employment managers acknowledged themselves capable of hiring on the spot for a variety of jobs. Yet the stories which the patients themselves readily and willingly unfolded upon very slight questioning were immediately indicative to the employment managers that the hiring of these applicants would have been a dangerous or delicate business or a business requiring careful and special adjustments. We were able also to show cases in which the special features brought out by the physicians or the social workers proved of decisive value in solving the patient's own problem of making a living and the industrialist's problem of securing a very good workman. It is a well known and commonplace observation with employment managers and all who have to do with personnel that many a psychopathic, cranky, grouchy, queer, or otherwise difficult person may be just the man wanted for a special task. An outline of these Psychopathic Hospital clinics as given in the spring of 1919 to employment managers is being prepared for publication. Specifications for clinics of a like nature for employment managers in the various centers can readily be laid down, and some of these specifications will be published shortly.

I do not want to appear to "medicate" the problem too

much. The problem of mental hygiene is wider than medicine and wider than the branch of medicine that deals with nervous and mental disease. The problem touches mental and social sciences and arts of the greatest breadth. Yet the indispensable core of the problem may well turn out to be medical. I had the privilege, in the spring of 1917, of many remarkable hours of consultation with the late Carleton Parker. He had, as everybody knows, come to a view of the great importance of the underlying ideas of mental disease and defect in the problem of industrial unrest. Every psychiatrist who appeared on the Pacific Coast was eagerly interviewed by Parker for what said psychiatrist might have to say on problems like those of temperament, monotony, fatigue, and the like. It is a great wonder that an economist could have come independently to this point of view. Perhaps if more economists with thoroughly scientific training should live with workmen as Carleton Parker did with hoboes, the problems of hiring and firing, of promotion, of job selection, and in fact the entire problem of personnel, would get settled faster. Another economist, Professor Irving Fisher, has gone so far as to use the phrase "industrial psychiatry" in published work.

From the side of government and law, the work of Mackenzie King on industry and humanity has been mentioned above. This excellent work, despite the great breadth of the sciences and arts from which it draws, is in most ways a gigantic sermon for health. What Mackenzie King calls the law of peace, work, and health appears in parts of his work almost to reduce to health. The motto of the whole work is from Louis Pasteur: *Science will have tried, by obeying the law of humanity, to extend the frontiers of life.* It is extraordinary in how many places in Mackenzie King's book the ideas of mental hygiene are expressed, though without the use of the term itself. According to Mackenzie King, Pasteur first used the expression, *the law of peace, work, and health,* and opposed it to *the law of blood and death.* It is easy to see that human personality stands in the very center of recognition under Pasteur's law. Indeed, Mackenzie King specifically states this fact. Economists and sociologists rightly despise a good many biological and medical schemes for ex-

plaining or improving society. But the biologist and the physician no longer need to proclaim their own values when such diverse minds as those of Carleton Parker, Irving Fisher, and Mackenzie King are willing to admit the central and indispensable importance of the medical and mental points of view.

There is a brief, but interesting literature from the side of medical men themselves. The work on unemployment and personality at the Psychopathic Hospital, above mentioned, led to early publication by Herman M. Adler, M.D., now criminologist to the state of Illinois, but at the time of this work chief of staff at the Psychopathic Hospital.[3] On the basis of concrete case material, Adler rendered conclusions as follows:

"I. There are individuals in the community who for a variety of reasons are not able to regulate their conduct on the basis of experience. One of the difficulties that such individuals get into is unemployment. The results of their unemployment bring hardships on themselves and on their dependents.

"II. While some of these individuals show defects of such a severe nature that they may be regarded as hopeless and, therefore, can be segregated, there are others in whom the deviation from the normal is not sufficient to make them incapable of supporting themselves at all times and it is unwise to segregate them and prohibitively expensive.

"III. From our analysis it appears that there are two types of individuals that experience these difficulties. One type, which is grouped under the headings of inadequate and paranoid, is afflicted with certain characteristics of personality which are not amenable to treatment. To maintain these people in the community, it is necessary to modify their environment so far as possible, in order to prevent, in the first place, the calling out of their peculiar reactions and, furthermore, to prevent their suffering the results of their acts; in other words, to keep a man 'on the job' in spite of his personal unpopularity or inadequacy. The other type, grouped under the heading of emotionally unstable, suffers

[3] Unemployment and Personality: A Study of Psychopathic Cases. By Herman M. Adler, M.D. MENTAL HYGIENE, Vol. I, pp. 16-24, January, 1917.

from the results of temperament. These individuals are subject to variations of temperament, and the treatment of their unemployment must be guided by a knowledge of their tendencies, so that environment on the one hand can be suitably influenced or chosen for them and that the individuals themselves may be trained to counteract their impulses to some extent.''

Miss Mary C. Jarrett, now working on this topic under the Engineering Foundation, published certain brief studies of the psychopathic employee based upon the results of her Psychopathic Hospital work.[4] In general she found ''employers quite willing to employ patients whose mental conditions and industrial efficiency are frankly described and to retain them as long as they are able to do the work. Understood by their employers and taught to understand themselves, psychopathic individuals who would otherwise be thrown out of industry may keep their places as efficient employees.'' She concluded by stating that an important division of social psychiatry would be the application of psychiatric knowledge to industrial problems. She charted six cases in particular—one of dementia praecox, one of depression of an alcoholic, one of neurasthenia, one of pronounced alcoholic psychosis, one of a peculiar form of alcoholic jealousy, and one of general paresis —which occurred respectively in a machinist, a tailor, a clothes presser, a packer, a teamster, and another machinist, all of which cases, through the efforts of physicians and psychiatric social workers, were industrially adjusted. Alcoholism, in some of this group of cases, may of course be regarded as one of the symptoms of a psychopathic constitution, exaggerating the original defect. It will be interesting to note whether national prohibition will abolish these problems. It is highly probable that many problems will not get abolished, but will be merely simplified.

In a later paper, Miss Jarrett has discussed what she has termed shell-shock analogues under civilian conditions.[5] She says concerning the war neuroses themselves: ''The con-

[4] See note 1, p. 50.

[5] Shell-Shock Analogues: Neuroses in Civil Life Having a Sudden or Critical Origin. By Mary C. Jarrett. *Medicine and Surgery*, Vol. II, pp. 266-80. March, 1918.

siderations that strike the psychiatric social worker in this situation are, first, the desire that this new, widespread knowledge of the neuroses that war is making prominent may be turned to the advantage and relief of civilians who suffer from similar troubles and receive inadequate consideration; second, that experience in the social care of civil cases of a similar nature may be used to advantage in restoring soldiers suffering from shell shock to normal social condition; third, that a thorough, intelligent public understanding of these disorders should be established against the day when the soldier who suffered shell shock shall have again become a civilian, and the cause of his trouble may not be remembered acutely enough to arouse sympathy for symptoms that still persist.''

She found that the analogues of shell shock in civil life appeared frequently at the Psychopathic Hospital. The range of exciting causes was from trivial incidents, such as a quarrel or a reprimand, to a profound shock, such as an accident in which the patient is severely injured and a companion killed. She found another feature of the situation which the layman cannot readily understand—namely, that the severity of the symptoms is not at all proportionate to the size or apparent importance of the cause. Treatment, however, must be relative to the gravity of the disease and not to the nature of the particular strain or shock that induced the condition. She narrates cases in detail to show, first, certain failures in social treatment which came about through lack of medical resources and inability to compel treatment; secondly, cases of pronounced success obtained by comparatively slight service, such as advice to the family or finding the patient a suitable position; and, thirdly, cases in which results were obtainable only with the most intensive social care. These cases included a failure to cure a perfectly curable neurosis in an Italian laborer simply because medical facilities were not available in his home town and he could not be brought to a central clinic; also, cases of character change following accident, cases of amnesia, and the like. Some of these cases might seem to run far afield from industry, but Miss Jarrett was able to find important connections between them and a variety of

employment situations, with the net result, in many instances, of complete adjustment. Something like half the cases of social work in mental-hygiene clinics, such as that of the Psychopathic Hospital in Boston, will be found to throw light on various aspects of the employment problem.

Readers of engineering journals are familiar with turnover analyses in which sizable lists of the causes of discharge and unemployment are to be found. Jau Don Ball[6] gives certain methods of examination which he has used, in his own phrase, "as scientific aids to industrial efficiency." It would be equally true to say that Ball's methods and those of others engaged in this work are also practical aids to industrial welfare. Efficiency experts and welfare workers can unite on this mental-hygiene program. Ball gives the following list of persons that might especially come under examination: *queer guys, eccentrics, disturbers, querulous persons, unreliable and unstable fellows, misfits, the irritable, the sullen, the socially disgruntled, unsociable, negative, conscientious, litigious, bear-a-grudge, peculiar, glad-hand, gossipy, roving, restless, malicious, lying, swindling, sex pervert, false accuser, abnormal-suggestibility,* and *mental-twist* types.

One might contrast this list of persons, who are either psychopaths or near-psychopaths, or would obviously benefit by the kind of analysis that the psychiatrist would bring, with the following list of causes for removal from pay roll quoted by Mr. Thomas T. Reed from a well-known department-store blank form:

Other Positions	1. Better salary
	2. Former position
	3. Going into business
	4. More promising position
	5. Position nearer home
	6. To learn trade
	Leaving city
	To marry
	On account of health
Health	1. Own accord
	2. Division superintendent's a/c.
	Doctor's orders

[6] Ball, Jau Don, M.D. The Correlation of Neurology, Psychiatry, Psychology and General Medicine as Scientific Aids to Industrial Efficiency. *American Journal of Insanity*, 75:521-55, April, 1919.

Dissatisfied	1. Did not like supervision
	2. Distance too great
	3. Refused temporary work
	4. Refused to be transferred
	5. Resented criticism
	6. With salary
	7. Did not like working conditions
	8. Work too hard
Unsatisfactory	1. Agitator
	2. Carelessness
	3. Dishonesty
	4. Drinking
	5. Fighting
	6. Financial difficulties
	7. Indifference
	8. Insubordination
	9. Irregular attendance
	10. References
	11. Superintendent's private file
	12. Suspected of pilfering
	13. Too slow
	Reduction of force
No reason	1. To go to school
	2. To stay at home
	3. Worked less than two weeks—failed to report
	4. Worked more than two weeks—failed to report

Amongst these orders, the whole "dissatisfied" and most of the "unsatisfactory" groups are clearly subject to review from the point of view of mental hygiene. Particularly important from this standpoint are the dislike of supervision, the resentment of criticism, "too slow," "agitator," and even "dishonesty." Fully half of the causes enumerated in the list just given would give the mental hygienist pause. This is not to say that there are not plenty of dishonest people who are, so far as we know, merely delinquent and not psychopathic. There are doubtless plenty of instances in which the work assigned is actually too hard. There are also times, no doubt, when insubordination is a virtue and neither a vice nor a sign of mental disease. The point here made is simply that such causes as those above classified *suggest review* from a mental-hygiene point of view.

Ball in his paper describes the analysis of certain employees in a firm wherein, two months after Ball's examination, a strike occurred. Ball states that "in the case of every em-

ployee terminated for the group examined, whether discharged or voluntarily leaving, the prediction of a possible abnormal conduct or a dissatisfaction was made in the laboratory report and recommendations to the employer." And further, "according to the records, every one of the strikers had something wrong with him from a nervous or mental standpoint (nearly all having a psychopathic history); it was noted that, with three exceptions, the 'strikers' cited as agitators were among those grading the highest on the intelligence scale used." The intelligence scale used was a selection of tests made by Dr. A. W. Stearns during his naval work on the Pacific Coast, as examiner of recruits. Stearns promises an early publication of his work, of which an advance account was given at a national association of psychiatrists.

Of course no mental hygienist, least of all Drs. Ball and Stearns, would assert that all or many strikes could be prevented by advance studies of workmen. In fact, Ball specifically says that "it could not be concluded from this or any other examination that all strikers, whether agitators or not, are psychopaths; but this examination does show that the agitators in this group were the *self-assertive ones* and the ones grading the *highest in intelligence;* the others simply followed the leader." Nobody needs to say that there are not strikes that have purely economic causes. Nobody needs to say that there are not strikes and other labor troubles due to mental disease or character defect either in the employment managers and minor executives or in the plant owners themselves. Some of the very conditions that make for self-assertiveness and success of a sort amongst labor leaders are conditions that make for the success of financial magnates and captains of industry. Nobody claims 100 per cent efficiency for any of these or kindred proposals.

Ball draws several important conclusions. He thinks that what he calls medico-psychological laboratories (I think this term medico-psychological will hardly get across so well as the simpler and more comprehensive term, mental hygienic) ought to become principal departments of employment bureaus in large industrial organizations. Small plants might pool their interests for the establishment of such clearing houses. Labor organizations might well have, according to

Ball's suggestion, representatives in these bureaus. Ball calls attention to the value of this work to the individual, to the industrial plant (emphasizing here the enormous reduction of labor turnover), to labor organizations (stabilization of personnel), to a clearer understanding of general problems, and to the community. He thinks the community would be aided

(a) By a decrease in the numbers of the undesirable floating population
(b) By an increase in the number of persons who own their homes
(c) By a decrease in the number of strikes
(d) By a decrease in the number of accidents and deaths. This especially applies to public-service corporations. Instances are numerous where the lives of the public have been endangered by the *irresponsible acts* of morons—that is, high-grade feeble-minded—epileptics, and mentally and physically ill individuals in the employ of public-service corporations.

I believe that to make this community program most effective, we shall need to add to the laboratory for employment bureaus suggested by Ball all the facilities and arrangements for medical social work and in particular for psychiatric social work. In short, we shall be compelled in the end, I believe, to add to the staffs of large industrial organizations mental-hygiene clinics manned by competent practical psychologists and by psychiatric social workers. Very large or special plants or systems of plants might well require psychiatrists on full time, but all mental-hygiene clinics for industrial organizations should have available the services of consultant psychiatrists at least. It is not only that these staff members will aid the industrial employment managers by their special understanding of full-fledged grievances. They will also help to elucidate all the minor dissatisfactions and causes for removal or threatened removal from the pay roll.

In highly developed communities, where the public service has developed effective, stable mental-hygiene clinics—such as the out-patient departments of psychopathic hospitals—

large industries could send their special cases to these clinics for examination. Men who for any reason might have to be removed from the pay roll would then fall into the most adequate hands for their further social care. Man after man would get adjusted in other and more suitable employment through the procedures of competent social workers, supported by analyses of temperament and fitness provided by the consulting psychiatrist.

In other situations, it might prove a better plan for various firms to combine for the establishment of a common mental-hygiene clinic. Mutual aid would be given to the organizations by this plan of combination, and many a workman would soon find himself in a better job than he had ever had. As many contacts with the public service as possible should be made, since in this way some not altogether unreasonable suspicions by labor leaders will tend to be allayed. I have tried to indicate that the point of view of mental hygiene as applied to industry is neither a matter of efficiency alone nor a matter of welfare alone, but combines the two points of view.

Summary

1. The general object of this paper has been to set forth the existence and present rate of progress of a movement for the *mental hygiene* of industry.

2. This term *mental hygiene* is coming into general use to cover the expert activities of *psychiatrists* (i. e., medical men interested in the problems of mental disease, including the mildest forms of temperamental deviation), *psychologists* (i. e., scientific and theoretical experts, who are now turning their attention to methods of mental testing designed to improve and replace the hit-or-miss methods of the past), and various non-professional or semi-professional *aids* (such as *social workers* with special experience in character-handicap cases).

3. The recent improvements in employment management and all activities dealing with industrial personnel show that industry is ready for the new movement, and employment managers everywhere are displaying the keenest interest in the new ideas.

4. Meantime, the war-time results of the experts in mental hygiene enumerated above (paragraph 2) have given practical demonstration of the value of mental hygiene in a business partaking largely of the nature of industry—namely, the business of war.

5. The earlier literature of industry conclusively shows that the "mental hygiene of industry" is nothing new in its essence (witness many older references to the *human element,* etc.) but to-day's contribution is the organization of older interests for a systematic attack on industrial personnel problems.

6. The keynote of this systematic attack on industrial personnel problems by means of mental-hygienic data and methods is the pooling and coöperative combination of expert engineering interests and expert medical and psychological interests; in brief, *the invoking by the expert in industrial personnel of the aid of all available experts in personality,* to the study of which the whole personnel problem must reduce.

7. The interested personnel man or lay reader is implored not to take sides for one or another claim or counterclaim by medical men, psychologists, and others concerning the virtues of special methods. The topic is growing a little controversial; but on the whole the quarrels about method are superficial and the unanimity of experts extraordinary. No doubt the trials of the war served to mature and season the experts on all sides.

8. Another warning: Every time the world has tried to measure things more accurately, many foolish persons have risen to protest. Not a few medical men and psychologists will rise to say over the same formula against the mental hygiene of industry. It is to be hoped that, at this late date of the world's history, we can jump this zone of senseless protest against what must inevitably succeed—namely, a program of more expert study of anything whatever, including the human personality, wherever at work.

9. The movement for a mental hygiene of industry is neither an outgrowth of the efficiency movement—Taylorism and the like—nor of the workmen's welfare movement—economic interest in shorter hours, better working conditions, and the

like—though mental hygiene does effectively combine "efficiency" and "welfare"—as it were, F. W. Taylor and Jane Addams.

10. On the contrary, a stream of independent developments in our knowledge of personality (medical, psychological; illustrated, for example, by the kind of insight into human nature displayed by William James) is now pouring itself into a branch of engineering—personnel management—which has been running parallel for some time. Let us think of the movement in the terms, not of F. W. Taylor or of Jane Addams, but of William James.

11. The text contains sundry definitions and general statements on these lines. Future papers will amplify the account.

12. Perhaps the argument for a mental hygiene of industry may be put in the nutshell form as a question:

Why should not industrial managers seek the aid of (a) those who can measure at least a few of our mental capacities and have shown their abilities in war work, of (b) those who are the best specialists we yet have in temperament and the best experts in grievances yet developed, and of (c) others less professionally trained who are capable of tracing out or helping to trace out the actual situation of, per example, labor "turnover" as shown in the individual instance?

13. In short, why not help to push on the movement for individualization in industry that every one sees coming and ardently hopes for?

NOTE ON CERTAIN TERMS

In the text of this article, the distinction between psychologists and psychiatrists is clearly enough drawn. The psychologist in the past has been something of a theorist, and the so-called "brass instrument" psychology was a matter of college laboratories. At the best, the results of these psychologists stood to industry, education, and the arts as theoretical physics stands to railroad engineering. Even before the war, however, the terms "psychology" and "efficiency" were being used together. The world was, therefore, not at all unprepared for such practical work as that of Lieutenant Commander Raymond Dodge in certain naval problems, of Colonel W. D. Scott in the classification of army personnel, and of Major Robert M. Yerkes in mental tests of recruits.

This work by psychologists is distinct from the work of psychiatrists. Psychiatrists are medical practitioners in the field of mental diseases. Psychiatrists used to be termed "alienists," dealing, as they were thought to do, with alienations of mind. Psychiatrist is a better and broader term

which has now come into general use and is rapidly supplanting the term alienist, which latter term might perhaps be reserved for medical men engaged in the medico-legal problem of responsibility or of internment in asylums. It is important to insist that the psychiatrist now ranges over a much broader field than his colleague, the medico-legal alienist, or than any one would have been ready to admit in the last century. His perview includes nowadays the slightest of character defects as well as the most serious of mental diseases.

Writing as I here write for employment managers and other laymen not skilled in the various mental sciences and arts, perhaps I should warn the investigator that the popular mind is rather inclined to talk of all these matters as "psychology." Perhaps the term "psychology" does in some broad sense include all the mental sciences, but it is more than doubtful whether it ought to include or does include the various mental arts and types of technique—the so-called psycho technique of some writers. The practical thing for the investigating layman to bear in mind is that if he goes to the college professor of psychology, he may find somebody rather unsympathetic to mental tests and inclined to underrate their importance. On the other hand, if he goes to consult an applied psychologist, he may find an ardent mental tester who is not at all interested in what he thinks are the rough-and-ready and inexact conclusions concerning temperament, character, instincts, and impulses which the less laboratory-minded man is willing to discuss. Now and then the investigating layman may meet an enthusiastic psychologist or physician prepared to explain the majority of difficulties on some special basis—e. g., the fear neurosis or sex. In the endeavor to make up his mind about these things, the peripatetic layman may run into sundry prejudices between psychologists and physicians or between certain groups of psychologists and physicians and certain other groups of psychologists and physicians. The layman must take heart. He must extract the honey of mental hygiene from a great variety of flowers, each, no doubt, with what you might call a different honey index.

I have occasionally used the term "neurologist" and even the term "neuropsychiatrist." There are certain differences between neurologists and psychiatrists, and there is coming to be a group of men who, under the name of neuropsychiatrists, fulfill effectively both functions. From the standpoint of mental hygiene as applied to industry, I have no doubt that men calling themselves neurologists are precisely as good mental hygienists as their brethren called psychiatrists. The neurologist is a medical practitioner who deals primarily with nervous diseases. He is the sort of man naturally called in for a case of occupation neurosis—writer's cramp—and that sort of thing. The psychiatrist or alienist, as he was formerly called, is the sort of man who would be called in for a case of sudden outbreak of excitement. But the two fields so overlap that the distinction is likely to fall. As for the difference between certain diseases called nervous and some of the mild so-called mental diseases—well, it would puzzle the sleuthiest to make a distinction.

But although the layman need not particularly distinguish between neurology and psychiatry in his search for mental-hygienic points, he must

beware of thinking that he can get such points from any and every medical practitioner. He cannot. The development of public health did not primarily include mental hygiene. Public-health work probably started, as a rule, in the arousal of the community's interest in sewage and simple sanitation problems. Next the public-health specialists turned from these relatively simple engineering problems to bacteriology and the prevention of infectious diseases, at first through water supply and thereafter by a variety of measures. Latterly, however, we are witnessing the public-health workers go over to special studies in personal hygiene. Studies of personal hygiene culminate in mental hygiene. The long-separate flow of work in mental hygiene will shortly fuse with that of public-health in general. The public-health movement was for decades a movement for bodily health. It must now become a movement for public-health, bodily and mental. For example, the new school of industrial hygiene in Harvard University will pay great attention to the various problems of mental hygiene. The Journal of Industrial Hygiene, already in its first volume, contains reviews of mental-hygienic interest. The United States Public Health Service has also developed, alongside of its personnel for bodily-health measures, the beginnings of a personnel for mental-health measures. In the future, no doubt, every practitioner of medicine will get a grounding in mental hygiene. Parallel with this highly desirable state of affairs, the rapidly growing group of public-health nurses may, at some future time, get training in the principles of mental hygiene, so that they may function in this field. Up to the present time, however, the majority of physicians and the majority of nurses, whether or no these physicians or nurses belong to the public-health school, have not had such training or direction of interest as to make them very helpful in the mental hygiene of industry as here conceived.

Of course any clever layman can see some things with half an eye. The point of the movement for the mental hygiene of industry consists, not in calling the attention of clever laymen to some obvious facts, but in suggesting to the clever layman that he look into the good work that has been recently accomplished in the various departments of mental hygiene, such as applied psychology, psychiatry, and psychiatric social work. "Life" said Herbert Spencer, "is an adjustment of inner to outer relations." Most of the study of economists and political scientists has been spent on the outer relations. A good deal of new work has been done on inner relations, both normal and abnormal, by psychologists and physicians. Out of the philanthropy of the past has grown the humane, but also efficient, social work of the present day. The social workers must now do their best to aid in the adjustments of all these relations. This is a gigantic task, but is there anything to do but go to it, approaching it with all the expert knowledge possible?

THE "NERVOUSNESS" OF THE JEW

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THE subject of racial disease has the added fascination that history, biology, and sociology lend to medicine. On a broad canvas pathology can more easily be traced than on a minute one, for individual and minute variations thus tend to standardize themselves. How much of history is written in racial diseases can easily be summarized by those who know how profoundly malaria, yellow fever, hookworm disease, gonorrhea, and syphilis have influenced the world. Conversely, and this is the theme that I wish to develop, we may read something of the history of a race in the symptoms of the patient that stands before us.

Now there need be no difference of opinion about the liability of the Jews to psychoneuroses. Step into any clinic for nervous diseases in any large city in Europe or America and the Jew is unduly represented amongst the patients. Figures similar to those I have collected in the Psychopathic Out-patient Department of the Boston State Hospital can be shown to be true for any clinic in Boston or if we follow the neurologist and psychiatrist into his private office. It is easy to dismiss the subject by saying that there is a predisposition in the race that accounts for this undue occurrence of mental disease, but I contend that this is a cheap solution in that it ascribes causation to a totally unknown factor, heredity, whereas environment and history can easily be examined and analyzed as to causative influences. Analysis of the life conditions of the Jews in the present day and historically needs to be made and perhaps is best made by a Jew familiar with the intimate life and history of his people.

The thesis that I wish to develop essentially is this: *as important for practical purpose as biological heredity, and*

often mistaken for it, is what we may term social heredity. By this is meant that groups of life factors may be handed down for generations and may influence the life of every individual in the race as potently as if a change had occurred in the stock.

It is idle, of course, to deny that the Jew has an innate character, different from that of other races, which perhaps predisposes him to psychoneuroses and other mental diseases. Unquestionably deeply emotional, clinging to belief and opinion with a tenacity unparalleled in the history of the world, extremely active mentally, and in point of intellectual achievement to be compared only with the great races of the world, he is curiously passive in his resistance and curiously indomitable in his hold on life and success. Accused of materialism and yet furnishing proportionately more social reformers than any other race; accused of materialism and yet responsible for the two most ethical religions in the world; said to be dominated by love of gain, but the birthplace of the ethics that govern his accusers, the Western peoples; a race of contradictions, inconsistencies, strongly individualistic and extraordinarily social, it may well be that such a soil would produce great failure as well as great success, psychoneurosis as well as genius.

But even racial character may be a matter of social heredity. In the face of what we know about the life factors of the Jew, and of the extraordinary changes that have taken place in his character in the last generation, no surmises as to an innate character are permissible. Let us, then, examine these life factors, governed by the thesis that social heredity has been established through these factors. *First,* we may state that the main factor and the one out of which the others arose has been the persecution of the Jew. Because he felt his religion to be superior to those of the nations with whom he came in contact, and because he refused in any way to acknowledge the potency or the reality of the gods of the people amongst whom he lodged, he was looked upon as unsociable, different, and because of this a sinister person, one to be restricted and guarded against. *The basis of dislike is normally unlikeness.* The restrictions prior to the Christian era are of no import-

ance to us, but with the rise of Christianity, a competing religion, what was the mother religion became a thing to be proscribed and harried. Through the pagans the Jew suffered no serious misfortunes; with the rise of the Christian church the blackest chapter in Jewish history begins. The Christian church fell into a state of ambivalence. In its attitude toward the Jews as Christ killers and as refusing to acknowledge his Messianic character, it looked upon them as subjects for persecution and extermination; but it adopted a curious restricting attitude in addition—that the Jews, having been witnesses of the Passion, must also witness the Triumph. Therefore, they were to be kept alive, but to be made miserable, kept from real living. To the religious basis for persecution we add this—that with the downfall of the Roman Empire, the Jews and Arabs alone kept the torch of culture and science lit. In other words, the Jew was easily superior in these matters to his uncouth, warriorlike hosts. This superiority brought about a jealousy, a fear of the ability of the Jew; a fear that has never been stilled, though the culture of the Western races has reached a very high plane; a fear that yet actuates most of the hostile feeling of neighboring races.

Now the restrictions that arose from this hostile attitude gradually increased in number and gradually narrowed the activities of the Jew. For many centuries, and especially in those countries where Christianity was late in coming, as in Russia, many fields of activity were open to him. He was a handicraftsman, an agriculturist, as well as a merchant, a peddler, etc. But with the rise of guilds, with the rise of shopkeeping classes amongst the Gentiles, and especially with the amalgamation of church and state after the Crusades, the Jew became excluded from the soil, in which condition he remained down to our own day, and still remains in such countries as Russia, Poland, and Roumania, where the bulk of the Jews live. He was forbidden to become a handicraftsman, though, previous to his exclusion, in such countries as Italy he was the main handicraftsman of the country. *In other words, he was excluded from all occupations in the pursuit of which the manual motor side of his nature might find expression.*

Because of the fact that he spoke many languages, because the Jews were scattered in small colonies, and because the Gentile looked down upon mercantile life as a sort of usury, the Jew shifted to mercantile life, and if not the greatest factor in establishing international banking, was at least exceedingly prominent. As time went on, with the rise of the kings into power and the crumbling of the feudal system, the Jews became the tax collectors of Europe, and thus, while exceedingly useful to the kings, became their scapegoats. What I wish to emphasize in this is that here was a factor that tended to make a race of inferior physique, in that all those occupations that tend to develop strength of body and hardihood were forbidden. The Jew became a sort of sedentary adventurer, living by his wits. Having a full share of brains, he was quick to see his advantage and to form a dislike for the occupations from which he was excluded.

This brought about another factor in the life history of the race and that is its urban character. Until the nineteenth century became distinguished by the great urban movement, all of the races of Europe have been largely rural—agriculturists and peasants. The cities were small and inconspicuous, comparatively speaking, and the vast bulk of the people lived on the land. That urban life develops neurasthenia and the like conditions is an old story. Any nervous organization that stands country life may go to pieces when assailed by the extraordinary stimuli of the city. Now the Jews became exclusively an urban people. They lived in small towns, perhaps, but in crowded, dirty, disagreeable towns. In this urban life, not only was a sedentary life necessary, but the race developed a curious antipathy to exercise and even to play. For centuries the Jews were a race that despised sports and discountenanced play. The importance of the basal movements—i. e., the large movements of sports and play—has been wonderfully emphasized by Stanley Hall. They form an incomparable avenue of discharge for nervous tension. They breed confidence in oneself. Being extensor in their character, they allow for the rise of pride and courage. Circumstances excluded the Jew from their wholesome influence, and the children of the race grew up to be very serious, very earnest,

too early devoted to mature efforts, excessively cerebral in their activities, and not sufficiently strenuous physically. *In other words, the Jew, through his restrictions, was cheated out of childhood.*

This urban, sedentary trend would in itself have sufficed to change the character of the Jew. In addition, because of their exclusion from friendly and wholesome contact with other races, the Jews became more clannish. The ghetto life was not only unwholesome physically, but unwholesome mentally, emotionally, and spiritually. Living in constant dread of massacre, exposed to ridicule, degradation, and more serious disaster, the race developed an apprehensiveness and acquired a lowered threshold for fear stimuli. The ghetto life developed an overintimate and close family life. On its plus side, this family life was characterized by devotion and purity, and on its minus side was a reverberating emotionality which intensified the neurasthenic trend of the Jewish child. There was little rest or quiet in the small dwelling crowded with children watched over by apprehensive parents; guarded so well, indeed, that the Jewish infant and child death rate for centuries has been the lowest of any race, but with the evil result that this intense care and solicitude increased the fear attitude of the Jew. Thus we may add to the urban, sedentary, cerebral character of the Jew an apprehensiveness and an emotionality that arose from the conditions of life to which his Christian neighbors subjected him.

I need not go into detail concerning the persecution of the Jew. Every untoward event that occurred in the town or country in which he dwelt was in part ascribed to him, often directly to his evil and even magical efforts, indirectly because God was angry that Christ killers lived and were prosperous. For example, the black plague was a pestilence that occurred as the result of their evil tendencies, and they were accused of starting the great London fire. The most disastrous accusation of all was the infamous blood-ritual accusation. Some day historians will follow the lead of the anthropologists such as Frazier and correctly ascribe to superstition the leading place in the development of ideas. That historian will trace a good deal of the character of the Jew and much of his

unhappiness to this superstition of his neighbors that the Jews required the blood of a Christian child to celebrate the Passover ritual.

In addition, of course, to the persecution that was expressed in massacre and insult and restriction of occupation, there was the liability to expulsion from the land of his birth at any moment. The Jews were successively expelled from England, France, and Spain in the years 1190, 1291, and 1391, and they were expelled from various cities in Italy at different times. Gold, cash, became the only stable good of the world to the Jew because he had no other property that he could be sure of. The hate of his Gentile neighbor for the Jew was fully returned. He did not wish to be like him in any way. He rejected his learning, his art, and his sports together with his food and his religion.

But the feeling of hate and contempt was not the main emotional trait that arose from the centuries of persecution. Apprehensiveness I have already spoken of, but in addition there was a melancholy which expressed itself in motto, in song, and in the Jewish literature. *"Der Yid hat kein masel."* —"The Jew has no luck"—was the opinion of the Jew of himself. Despite an occasional ephemeral prosperity, the bulk of the race was undernourished, underdeveloped, and overstimulated mentally and emotionally. Here it is well to emphasize what is well known, yet commonly overlooked. Emotion is not a matter of mind; it is something that concerns the whole body. It is an intense display of somatic activity, in which blood vessels, glands, great viscera, and skeletal muscles all take part. An emotion may disturb the functions of the organism, or perhaps it had bettter be stated that a pathological emotion *is* a pathological function—*is* a loss of appetite, a spasm of intestine or bladder, a drying up of milk ducts, etc. Fear emotions especially bring about disorders in function of a persistent type, such as those seen in the psychoneuroses, and may, so far as we know, produce little by little permanent structural changes in the organism. That the liability to arterio-sclerosis and diabetes that exists amongst the Jew can be related to his unfavorable emotion-engendering environment may be a far-fetched assumption which I believe, nevertheless, to be true.

Now every race—all human beings, in fact—may be classified roughly into two groups—the extrospective and the introspective, the objectively minded and the subjectively minded. It is conceded on all sides that to be objectively minded is healthier from the psychological standpoint, though this life is not, perhaps, so rich in genius, in artistic and creative ability. Whatever introspective tendency existed in the Jewish race as a whole and in its individuals was exaggerated by the exclusion from play, sports, military life, and from occupations such as the handicrafts. He who tended to be introspective became deeply so, and this introspection was deeply apprehensive and melancholy. An intensity of character developed, an extraordinary eagerness and overseriousness of purpose which led in two directions in so far as the fate of each individual was concerned. It led to great success, and I need not point out how marvelously successful in many directions the Jew has been. In our own profession, since the Jew has been allowed to participate in it within the last hundred years, there have arisen the commanding figures of Henle, Cohnheim, Weigert, Ehrlich, Freud, and Barany, to say nothing of the Rombergs, Flexners, Loebs, and the innumerable lesser lights without whom no medical account of the nineteenth and twentieth centuries would be complete. But while this intensity led to great success, it also led to *poignant failure.* The Jew who has not succeeded or who is struggling feels his situation the more keenly because of the intensity of purpose that has been frustrated.

How quickly racial characters can be changed under a fostering environment may be exemplified by the development of the last generation in Jewish life in the free countries of Europe and America. Intermarriage, especially in Germany, Scandinavia, and France, are so extraordinarily prevalent that, unless checked, the Jew will disappear in these countries, to be merged into the general population. The intensely religious character of the Jew disappears in America in one generation. He gives up his kosher, his Sabbath, his traditional religion in general, as if by magic. *What persecution could not do throughout the centuries, toleration does in a generation.* The alleged stinginess and miserliness of the immigrant Jew can certainly not be charged against his children. Of all

the prodigal spenders in America, the American Jew stands foremost. Nothing is too good for him or his, and he is a sport of the first water, totally and completely different from his father. The dislike of the Jew for athletics and especially for all combatant forms has been supplanted by the surprising phenomenon of the Jewish prize fighter, who in the weights, from the lowest up to the light heavy-weight, outclasses proportionately to his numbers any race. The race that produces so many Phi Beta Kappa scholars likewise produces the champion prize fighter. Nor can any lack of gameness be charged to these representatives of Israel. Shrewd, scientific, and powerful, the yellow streak is surprisingly uncommon amongst the boxers of the race that once wore the yellow gabardine.

This dissolution of Jewish life that has taken place in America is also responsible in part for the psychoneuroses that we witness amongst the American Jews of the first generation. A surprising change in ideals and in life-governing notions works havoc with the less stable of the race. But the second generation, brought up in American methods, learning early to fight physically, taking part in athletics in everincreasing numbers, discarding the intensely communal life of the past, coming into contact with the less emotional, more controlled life of the neighboring Gentile, is being changed in character, has much less liability to the psychoneuroses. A lover of his race will counsel control of emotion in the family and the bringing of discipline into the home, participation in sports, less intensity upon scholarly and financial success, more handicraftsmanship, and more manual motor effort. The urban life of the race is now fostered by the urban trend of the entire world, and it would be impossible to make the Jew into a rural dweller except, perhaps, in his own home land. But it seems to me possible, as well as eminently desirable, that the steps which I have outlined above will bring about a new social heredity for the Jew, one that will not rob him of his great virtues, but will lessen his liability to the psychoneuroses.

ANXIETY AND FEAR*

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PROBABLY nowhere on this program is there a paper whose title is so readily understood, both by the physician and the layman, as the title of this paper. All are familiar with the terms anxiety and fear and understand their meaning. And yet there are few subjects about which there is so much misunderstanding and such general lack of information. It is evident, of course, that it will not be possible, within the limits of a fifteen-minute paper, to describe adequately these conditions, their ramifications, their full significance, and their treatment. What I shall hope to do will be to set before you as clearly as I can a few fundamental considerations—a mere outline, as it were—in the hope that this will be found useful as a beginning in clarifying the situation for that large group who are looking for help and for those others who wish better to understand in order to render help.

The elaborate precautions nature has taken to protect our physical self are familiar to us. By means of instantaneously working, involuntary reflex actions—the wink of an eyelid, the jump on being startled—physical protection is provided. To these involuntary protections we have ourselves added voluntary protections—houses, clothes, the storage of food, etc. But assaults upon our physical self are not the most grievous assaults we may suffer. More hurtful, more painful, frequently more permanent in their effects than assaults upon our physical self are assaults upon our personality. It is not surprising, therefore, that, analogous to the voluntary and involuntary protections provided against physical assaults, are to be found conscious and unconscious means of protection against spiritual—in the broadest sense—assault. These are probably less commonly known.

The influence of some of these mechanisms is felt in both the physical and the mental fields, as, for example, the in-

* Read before the Personal Hygiene Section of the American Public Health Association, New Orleans, Louisiana, October 29, 1919.

stincts—the instinct of self-preservation, the sex instinct, the instinct of acquisition and of pugnacity—while others are essentially protective of mental integrity.

As protective agencies alone, these mechanisms are important, but of more concern to us here is the frequent failure of a mechanism, the defective mechanism, or the false mechanism. For mechanisms, whether physical or mental, do, as we all know, fail at times. The swish of an eyelash is not always quick enough, or may become overemphasized to such an extent as to be more a hindrance than a help: the person who jumps at the sound of every noise will probably protect himself from sudden assault, but in the meantime he will have made for himself much unnecessary trouble. We will discuss here briefly, then, only those more common mechanisms which easily become defective or are in themselves false.

As individuals grow older and assume greater responsibilities, and as living becomes increasingly complex and adjustment more and more difficult, some are likely to find themselves endeavoring to cut through the maze. Effort may be directed towards simplification, towards a compromise between instincts and social demand, or towards harmonizing reality with imagery—the world as we find it to be with the world as we once thought it to be or as we now wish it to be. Forgetfulness is found useful. Memories that are hurtful are pushed away, are crowded out—we forget. In situations which have been frankly faced and truly evaluated, the mechanism is protectful and helpful. When the real situation is evaded and the effort to forget is but an attempt to deny the real situation and is an expression of unwillingness to face frankly what may be a disagreeable fact or situation, then the mechanism frequently becomes a sharp-edged tool that injures those who, without understanding, attempt to use it. An attempt to evade the real issue by repressing it is analogous to an attempt to *crush* a rebellion instead of removing its cause.

Rationalization may be called upon—an attempt to explain a painful situation, not in terms of the actual fact, which is disagreeable, but in terms more acceptable to the individual. "I cannot apply for a commission in the medical corps, because if I should go, there would not be enough medical

men left in my community." To be sure, this statement was not a mere "rationalization" for many; for many it was a statement of fact. But for others it served to explain their failure to apply for a commission, not in terms of the real reason—their disinclination, which it would have been disagreeable for them to admit even to themselves—but in false terms, more agreeable to admit.

One may attempt to adapt one's self to an unattainable desire by denying the existence of the desire and minimizing the value of the thing wished for. The wish is genuine, nevertheless, and assuming a false attitude merely makes it much harder to meet any later situation in which the wish could and should be realized.[1]

Or, conceding the value of an end desired, but lacking the strength of will to attain it directly, one may attempt to meet the situation by imagining a realization—a popular way of escaping reality and living in the world of imagery and day-dreaming.[2] This mechanism has its good side, but as James has pointed out, after such a debauch let the engendered good impulses flow into some activity, if it is no more than being good to your aunt or giving up your seat in a street car. The dementia-praecox patient who for the past ten years has helped make the beds and scrub the floor in the local state hospital, but who all this time has been to herself the Queen of Sheba, is an example of the life of phantasy in its extremest form.

Individuals with feelings of inadequacies frequently buckle about themselves an armor of hauteur—reënforce their egoes, as it were, with an attitude and feeling of superiority, as if by this means to frighten away attack.

These and many other agencies are called upon in various conflicts, for conflict is our part—adaptation, compromise, conflict between complex and simple, reality and unreality, the social order and instinct. The latter, of which the other conflicts are largely a part, has probably what we may call the greatest "morbidity rate" and therefore must have a place in our discussion.

1 Wells, Frederic Lyman. Mental Adaptation. MENTAL HYGIENE, Vol. I, pp. 60-80, January, 1917.

2 Wells, Locus cit.

We cannot live a wholly instinctive life. In order that we may live together as a society, compromise is necessary. Society creates arbitrary rules for our guidance. These rules are necessary and are for a good purpose, but have been formulated at various times and under varying conditions, and are sometimes based on reliable biological information and sometimes on partial or erroneous information. Compromise, therefore, is inevitable, and a conflict arises between instincts, with their consequent desires and emotions, on the one hand, and, on the other, the social demand, with its bulwark of training and education often implanted at such an early age as to have become almost a part of the individual. While all have the same instincts and the same physical organs with which to make adjustments in accordance with the social order, no two individuals possess a like quantity or quality of adaptive power. Every individual varies, therefore, from every other in his ability properly to adjust, and on a basis, then, of inherent differences in the make-up of the individual, varying types of educational and environmental influences come in further to complicate the situation. We are not surprised, therefore, as we look about us, to find all degrees of adjustment and maladjustment, ranging from contentment and efficiency through restlessness and unhappiness to frank failure in disease and even to outward revolt in what society chooses to call a-social or criminal conduct.

While each has his difficulties, most individuals eventually arrive at some acceptable compromise. The mechanisms used vary with the individual. Some, as we have indicated before, seek consciously to simplify their lives. Others take recourse in religion. Others pour their energies into congenial pursuits a little aside from the main current of their lives. A residuum of the conflict in such instances is frequently found in an undercurrent of unhappiness, a feeling of discontent and lack of full satisfaction, but life is on the whole livable for these individuals, and they are in the main happy and contented and efficient.

But others—and the number is large in the aggregate—find the conflict too difficult, too complex, or their equipment for meeting it inadequate. Short cuts in an effort to simplify or localize, as it were, the general conflict are therefore made,

and the individual takes refuge in a neurosis or a psychosis. The process is of course an unconscious one. Illustrations of these neuroses and psychoses can readily be found in civil life and practice, but there are probably no better illustrations than those contained in the reports of the neuropsychiatric officers who served in the A. E. F.

Salmon has well defined the war neurosis as an attempt on the part of an individual to escape from an intolerable situation. Faced with almost certain slaughter if he obeys his orders, or believing such to be the case, there arises within many a soldier a conflict between his instinct of self-preservation and his sense of duty. His instinct will drive him to flee; his sense of honor, his training as a soldier, his pride, his love of country and of an ideal—the social bulwark—demand that he obey. For many the situation is intolerable. Auto-suggestion—memory of a previously broken leg or of some other injury—or external suggestion—the sight of wounded being taken to the rear and safety—may enter in and there develops, as a compromise, an hysterical paralysis, or a blindness, a deafness, an aphonia, etc.—a fear reaction, albeit a reaction in general unconscious.

On his arrival at the hospital, it is found that there is nothing organically wrong with the patient. The leg is paralyzed or the eyes are blind, but with no organic injury to account for the condition. Treated as malingerers, called yellow or cowards, patients of this type are lost. Other conflicts are precipitated that further incapacitate. Treated for what they were, the nature of their difficulties intelligently explained to them, their feeling of disgrace, remorse, inadequacy, failure combated on the ground that they were not disgraced, that they were not in reality yellow, but that in the first test in a contest they did not fully understand they failed through an unconscious response to a normal instinct, a large per cent of these patients in the A. E. F. recovered and, with regained self-respect and confidence born of greater knowledge of themselves, returned to the line and "went through," many making the "supreme sacrifice."

This is an inadequate description of the war neurosis, nor can an adequate description be given here. It is but an attempt at a brief outline of a certain mechanism that pro-

duced a large number of neuroses during the war, and it is given in the hope that it may be helpful and suggestive in our attempt to understand the nature of fear and reactions to fear. For further discussion of this subject I would refer to the excellent articles by Salmon, Schwab, Thom, Rivers, and others.

Anxiety, as some one has said, is fear plus intelligence. The hysterical manifestations of fear represent a grosser type of reaction. Not that those who develop hysteria are unintelligent—they are intelligent; there could be little conflict were they not intelligent. It is, of course, a matter of relativity. The British reports show that hysterical manifestations were much more frequent among enlisted men than among officers, while anxiety neuroses were much more frequent among officers than among men.

The officer has the same instinct of self-preservation, with its consequent emotion of fear, but with his, on the whole, superior intelligence, his greater play of imagination, his more elaborate training, his fuller sense of responsibility, his more elaborated ideals of duty and self-control, the resulting conflict cannot so readily be solved by an hysterical short cut. Such a solution, even though unconscious, would be found unsatisfactory and in itself intolerable. The conflict is carried past the point of an hysterical short cut and manifests itself further on, as it were, in an increasing anxiety, a fear that when the test comes he will be inadequate, will be afraid, a feeling that he will prove a poor example before his men, with a resulting loss of morale among his men, failure, and disgrace. There is set up a vicious circle—anxiety, loss of sleep, loss of appetite, lessened efficiency, easy fatigue; greater anxiety, as evidences of his inadequacy and inefficiency become more marked, greater loss of sleep, greater fatigue, etc., etc.—until eventually the officer is incapacitated, is removed from his command, and is brought to the hospital. His suffering is intense, his sense of failure and disgrace deep, and the only way out is, as in the case of the hysterical soldier, a retracing of the way by which he came, a reëducation in the true sense, together with, of course, food and rest.

These, then, are the grosser manifestations of fear and anxiety, and, in general, the ways by which they come. They

are important to us because they are to be met with not only in military life, but in civil life as well. We know the number of those in the United States who each year enter hospitals for mental disease. We know, for example, that in the states of Massachusetts and New York some 12,000 persons who have failed more or less completely to work out a satisfactory solution to the puzzle of their lives enter the state hospitals each year. We have no means of knowing the number of persons who each year make partially successful compromises in the form of neuroses, but the experience of each of us teaches us that the number is large.

The number who are more successful—who retain a greater degree of efficiency, but whose efficiency is nevertheless interfered with and who are more or less unhappy and sometimes suffer acutely—is larger. I have in mind the worriers, the anxious. The number who find themselves in the clutches of worry and anxiety can be judged somewhat by the many calls for information that come to an organization like the National Committee for Mental Hygiene, the insistent demand of newspapers and magazines for material upon the subject, and the never-ending stream of books issued by publishers on this and kindred subjects.

Many thousands of individuals fall in a group of what we may call benign worriers. They are not seriously ill, but they suffer out of all proportion to the extent of their illness, and they cause many thousands more labor and unhappiness. We all know them. Is there help for them? That there may be less chronic invalidism, that what on its inception may seem to be benign may not become malignant, help should be given. Help will depend upon an understanding of the nature of the condition and a willingness to meet the issues involved. Worry and anxiety can be treated rationally only when it is realized that they are but symptoms and that treatment aimed at the symptom accomplishes no more here than in other fields of medicine. Anxiety, worry, fear, and their concomitants—insomnia, restlessness, unhappiness—mean conflict. The nature and cause of this conflict may be in the field of the conscious and obvious—the mother anxious over the son who has just left home to enter college, the business man worried over his investments or the preparation he has made for the

future of his family, the young man or woman concerned and undecided as to whether to resign one position to accept another. Most worries and anxieties are probably of this sort. The method of attack here is clear, although time does not permit of an elaboration, for this would bring us to a discussion that must be long of the general principles of mental hygiene. Whether the anxiety or worry in any given case is pathological or is becoming so can be judged by the relation of its degree to the cause. If the anxiety, worry, fear is out of all proportion to the apparent cause, then it is well to be on guard. This brings us to another point. The apparent or assigned cause, no matter how obvious or reasonable it may seem, is not always the real cause. In fact, in severe cases it very rarely is. The conflict may be an unconscious one. Here we are more likely to enter the field of the pathological, where, the source of the conflict not lying in consciousness, but being rooted in the unconscious, the patient, regardless of the reasons he may assign for his condition, is unaware of the real cause. Frink's patient Stella, for example, was terrorized by the fear of a fortune-teller whom she had once consulted. But the fortune-teller, the assigned cause, was not the real cause of Stella's fear, but the knowledge that she had tuberculosis, the thought that others might learn of this and that such knowledge might prevent her marriage. Stella was honest in her belief that her paralyzing fear was because of the fortune-teller, but a careful examination showed otherwise.

Some one has said that in getting at the cause of fear and anxiety, picks and shovels are sometimes used when a rake is all that is necessary. I would add that the prick of a sharp scalpel or a realignment by means of a spatula will sometimes suffice. It is well known that the senior medical student or the young interne is prone to overlook the obvious and to see only the obscure in making a diagnosis. He will not fail to have in mind the possibility of a brain tumor in accounting for a persistent headache, but will overlook the possibility of an eye strain. We must guard against the same danger here and not see in every case of worry and anxiety deep-lying, "terrible" causes, neglecting to evaluate properly material on the surface and at hand. Where a neurosis does not exist, where the anxiety, the worry, is not out of proportion to a

reasonably assignable cause, effort should first be made to influence the apparent cause producing the conflict, directing attention to the conflict and to the cause and not to the symptom of the conflict. This will mean attention to both elements in the conflict, changing such external elements as may be practicable, but more particularly reëstablishing perspective, directness, decision, and frankness on the part of the patient. But where the reaction is out of all proportion to a reasonably assignable cause, or where no reasonable cause can be found, then expert guidance and help must be found. "It is silly of John to be afraid to ride in the subway." "There is no sense in Mabel's being afraid to stay alone." "She faints every time she gets in a crowd just to attract attention." "She has everything in the world a woman should want. Why does she cry?" "She has nothing in the world to worry about, but she just will worry. She should take a trip and get away from herself." These judgments and the treatment they imply will not do. Here usually we have to deal with causes that are not conscious, and platitudes, good cheer, scolding, arguing, change of scene, travel, will not avail.

To summarize briefly: With qualitative and quantitative differences in the inherent ability of individuals to adapt themselves to a complex community life, with differing educational and environmental influences at play upon these inherent differences, there result, as we may expect, varying degrees of success in adjustment, from complete failure—those with psychoses—through partial success—the neuroses—to more or less complete success. On this scale appear those who suffer from fear and anxiety representing a degree of successful compromise. This compromise is born in conflict, conscious or unconscious, and the anxiety and fear represent the degree of failure or success and stand as the symptoms of the underlying difficulty. Whether benign or malignant, anxiety and fear mean conflict, and relief will be found only in meeting frankly the issues of the conflict. In most cases the cause of the conflict is apparent and can be dealt with. In many cases the apparent cause is not the real cause, which is more likely to be unconscious than conscious, and not until the source of the difficulty is revealed can relief be brought. But benign or malignant, conscious or unconscious, the mechanism and the general method of its handling are the same.

THREE CASES OF LARCENY IN WHICH THE ANTISOCIAL CONDUCT APPEARED TO REPRESENT AN EFFORT TO COMPENSATE FOR EMOTIONAL REPRESSION*

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IN the lives of each of the three women whom we are to describe, all of whom were arrested for larceny of various kinds, there is a history of much emotional disturbance, with neither an adequate emotional outlet nor a satisfactory adjustment. Each had experienced, over periods varying from seven to sixteen years, an emotional conflict that had been revealed to no one. Associated with much repressed desire, there was in two of the cases a sense of shame, while in the third there was a disappointment in the materialization of the dreams of childhood. In all three there was a total ignorance of sex life, and a fear of knowledge regarding it, which resulted in two cases from the sense of guilt that centered about early emotional experiences. One case might be considered subnormal mentally; the other two were classed by Dr. Mabel Fernald, of the Laboratory of Social Hygiene, as belonging to the superior group of normals. All three showed marked immaturity, either in their efforts to make the minor adjustments of everyday life or in their conception of adult problems and responsibilities.

Case I: Esther B., aged twenty-three, entered a department store and purchased a pair of scissors, asking the man behind the counter if she might return them if they did not prove to be satisfactory. A few minutes later, she cut a hand bag from a woman's arm. She was soon discovered and arrested. Because of many undetected thefts, which had been occurring in the store at the time, the store authorities were anxious to have the case prosecuted.

On looking into her history, the investigator found that the girl had led an exemplary life, had held for some years an

* Read in part before the American Medico-Psychological Association at the annual meeting in Philadelphia, June 18-20, 1919.

office position that entailed considerable responsibility, and had also been exceedingly active in church work. As the girl declared that she remembered nothing of what happened after she entered the store, and as the act seemed incompatible with what was known of her past life, it was thought by the court officials that it might be the result of some temporary mental aberration. The girl herself welcomed any attempt to explain what to her was a great mystery and was glad to have us examine her.

During two interviews, the following information was obtained. She was one of three children, her parents were living, and there was a very happy home life. When she was seven years old, her sex consciousness was aroused by a man with whom she studied music, while she was sitting at the piano playing her exercises. After a period of hesitation, during which time she went on with the lessons without protest, she asked to have them discontinued. As something derogatory had been learned of the man's reputation, the request was granted without much questioning. At the time, Esther gave no explanation of what had happened. She never talked the matter over with any one and grew up with a tremendous sense of guilt for which she sought consolation through religion. While constantly saying to herself that she was not to blame, she found solace in songs and sentiments written for the most penitent, such as, "He threw out the life-line to me," and, "There's a new name written down in glory. A sinner has come home." The desire to be saved and to save others had in it an obsessive quality that resulted from the sense of guilt which she felt, but which she was unwilling to admit to herself. This is comparable to the displacement of anxiety expressed so well by Frink* in his description of Stella, a case of anxiety hysteria.

When she was nineteen, Esther became acquainted with a sailor, who came to her room on one occasion and tried, she thinks, to assault her. She became unconscious at the time. In talking this over with her, we found that she had no idea what the possibilities of an assault were. She was wholly ignorant of all that relates to reproduction. Although this

* Frink, H. W. Morbid Fears and Compulsions. New York: Moffat, Yard, and Company, 1918.

episode troubled her to some extent, it was insignificant in its influence on her life as compared with the earlier experience.

The emotions that had been aroused in those early years finally found expression in the idea of an emotional union with God. She joined a mission in which revival meetings were common. A year previous to her arrest for the larceny of the bag, she had experienced on Easter Day a religious conversion. At the end of the fourth church service that she had attended during the day, she suddenly began to laugh while being urged to give herself to God. At that moment she felt an electric shock go through her. Her laughter continued all the way home and after she had gone to bed. Suddenly a great calm came upon her and, while still awake, she saw eight distinct visions, which she was later able to describe in detail. Following this, she had a feeling of complete union with God, with Whom she had talked in one of the visions. A year later than this, a short time before she attempted to steal the bag, she had lost the feeling of sympathy with God. Under the strain of unaccustomed responsibility in her position, she was more than ever oppressed by the sense of guilt resulting from her earlier experience, which never really left her except in moments of religious exaltation. She was no longer able to pray; she could not give herself to God.

When she was arrested, she remembered little about what had happened and slept much of the time for the following three days. At the end of the second day, a member of her family came to her and asked if there was anything he could do. She asked him to pray, thinking that if God would hear his prayer for her then, perhaps on the following day He would hear her. The next morning she felt that the power of prayer had returned to her, and she believed that she again had God's forgiveness and love. The following verses, as they stand, were written by the patient at this time:

Oh Savior come and help me
I need Thee Oh just now.
Come put Thine arm about me
And soothe my troubled brow.

The moments seem like hours
When burdened down like this
But Savior send Heavenly showers
And cover them with bliss.

I know that I have grieved Thee
I know that I've done wrong.
But right I know I ought to be
Condemned—without hope or song.

But Savior Thou hast loved me
Thou hast been my constant friend
And I know if I come again to Thee
Thou wilt love me to the end.

Oh Savior draw me close to Thee
Pull every vale aside
Until before Thy throne I'll be
And there with Thee abide.

I feel that I am with Thee, Lord
Close to Thy bleeding side.
Oh Savior now break every chord
And let me with Thee confide.

Oh Savior can it really be
That Thou hast turned Thine ear to me
And after hearing my cry, my plea,
Hast said, "Child, I have forgiven thee.

"Yes, but the confidence of an earthly friend
It may take quite some time
But, child, remember to the end
That I'll be always Thine.

"And if thou wilt walk in the light
And let me guide you while going thru'
There will always be in this Christian fight
A work for thee, my child, to do."

Judging from the limited material which we have at our disposal as a result of but two interviews, the following explanation of her conduct seems probable. A child who has displeased her parents, and from whom their favor is being withheld, may petulantly commit an even worse misdemeanor that perhaps involves personal danger, or may even make a pretense of committing suicide, in order to excite their sympathy, regain their favor, and prove their love. To Esther, to cut off and steal a hand bag was for some unknown reason the most terrible thing she could do. No significant associations with the article could be found. Furthermore, it had no

particular value in her eyes and she already possessed a similar one. Still, what she had done seemed to her the most horrible thing she could imagine; it was a kind of moral suicide. The whole episode was, we believe, an unconscious attempt to win back favor and to reëstablish the emotional relationship with God which she had previously felt and which to her compensated for her past "sin."

This is comparable to other expressions of emotion that are not infrequently used to end a period of tension and to effect a reconciliation. The following case may serve to illustrate this. A woman who was serving a sentence for larceny in an institution had periods of depression, varying in duration from four to ten days, when she ate nothing. During the attack, she was much agitated, frequently saying, "I didn't do it! Honestly, I didn't do it." The attack was usually precipitated by some emotional episode in her immediate environment. It almost invariably ended in an emotional explosion, such as breaking a pane of glass or throwing her dishes or perhaps even herself on the floor. This emotional explosion appeared to have the effect of a clearing-up shower. Her whole attitude of distress and tension then disappeared, and she was anxious to eat and continue her work as before. It was later discovered that the first period of starvation had followed the death of an illegitimate child which she was thought to have starved in order that she might not be prevented from returning to her husband and being forgiven by him for her unfaithfulness. Her protestations of innocence during the attack undoubtedly referred to this. After the attack was over, she manifested as much docility and penitence as a child might after receiving punishment, and shamefacedly promised to be more reasonable in the future.

Another situation in which complete reconciliation and subordination appear to be sought and in which the masochistic tendency is a little more pronounced is one that occurs not infrequently in reformatories when certain individuals beg for "punishment," threatening the worst possible behavior if it is not granted them. When possible, their request is gratified from a therapeutic standpoint, and they are allowed to get what to them is an equivalent of punishment in the form of special therapeutic treatment away from the main group,

which has become a source of much irritation. Such individuals often show a certain amount of periodicity in their erratic behavior, becoming more and more irritable, perhaps as a result of some constitutional defect, and a series of maladjustments to their environments accumulate which point to a crisis of some kind. Clark,* in his studies on epilepsy, describes a series of maladjustments that may precede the epileptic attack, which, he believes, is an attempt to compensate for an intolerable environment.

Feeling the inevitableness of the approaching crisis, our delinquents attempt to anticipate it by appearing to desire that which they feel will occur as the result of some overwhelming force within them. In this way they maintain a feeling of on-topness and consciously direct themselves to the point of reconciliation which follows either punishment or what to them is an equivalent. This final condition is one that they love when they reach it. It represents a climax that is a source of infinite satisfaction and happiness, and is similar to the feeling of reconciliation that Esther had when she was again able to pray.

At the examination, Esther remembered vaguely what had happened in the store. She had been told by others what had occurred, and she had difficulty in separating her memory of these accounts from the memory of the actual occurrence. It was found that even before the episode, as a result of the burden of her past life, she was beginning to be self-conscious, to feel that people were noticing what she believed to be peculiarities of her personal appearance and that they were talking about her. These ideas of reference that were beginning to develop disappeared after the two interviews during which it was possible to give Esther quite a different point of view from that which she had always maintained about the incidents of her early life, and to show her how she could find constructive social outlets for her energy.

There was nothing of consequence found in the physical examination, except that the patient was rather poorly developed and nourished. There was no history of epilepsy or evi-

* Clark, L. Pierce. Clinical Studies in Epilepsy. New York: G. E. Stechert and Company. A Further Study of Mental Content in Epilepsy. *Psychiatric Bulletin*, Vol. II, pp. 483-536, October, 1917.

dence of the epileptic personality. A few fainting attacks were described which had usually occurred in crowded subway trains. The family history was negative as far as could be ascertained.

Esther did not graduate from high school because she failed in the Regents Examinations, but she left school at nineteen at the end of the fourth year. Later, she took a course in stenography, and again left before graduating. For several years, she had held an office position, at fifteen dollars a week, as assistant to the supervisor of a number of stenographers. She herself, however, was not required to do stenographic work.

Esther's emotional conceptions appear to have remained on a childish level. The hunger that she displayed in devouring information about things that she should have known years earlier was pitiable, and the relief that she felt at unburdening her soul of what she considered her horrible sin was great.

Esther was seen before any sentence was imposed. Although we were unable to demonstrate to the judge the presence of any definite mental abnormality, as had perhaps been anticipated, still it was possible to point out the hysterical nature of past symptoms and to show the apparent relationship between the antisocial act and the emotional conflict. Fortunately, the case was dismissed. Had even a suspended sentence been imposed, it would, we feel, have added a burden that could easily have proved too much for one who had been struggling for years with an unnecessary and overpowering sense of guilt. It was hoped that the case would be spared the indictment, but this was not accomplished, and a pitiable scene occurred when the girl had her finger prints taken.

So far, in the year that has elapsed since the court episode, our patient has proved the decision of the court to have been a wise one. Freed from the horror of believing that she had committed an almost unpardonable sin, she has had a new lease of life, and by expressing her emotionalism in social ways, she has become more efficient and is mentally more stable. The possibility of a repetition of her antisocial act seems more and more remote.

This case has been an illuminating one as regards the value of examinations in the courts before sentence is imposed. The

ease with which the emotional difficulty could be tapped, and the patient's rapid response to treatment, demonstrate the desirability of the court clinic, where such cases should be weeded out before conviction.

Case II: Mabel C., a woman of twenty-five, was arrested for shoplifting to the extent of thousands of dollars. Her father was a man of culture who was sixty years old when he married her mother, then a woman of twenty, who had much musical ability. Mabel had been educated at private schools of good standing, and had traveled extensively in Europe, as well as in America. After leaving school at eighteen, she traveled about with a companion whom her father had chosen for her. The father was obliged to be in the West on a ranch, and she was unwilling to give up the companionship of her friends in order to lead such an isolated life, even though she had planned for years to settle down with him after she finished school. But business reverses had suddenly made her father old, and she no longer regarded him as the fascinating comrade of former years.

Mabel objected to the companion, who disapproved of certain of her friends and considered them frivolous and undesirable, although Mabel now admits that the judgment was correct. She entreated her father by letter to grant her permission to discharge the companion. Her father wished to postpone any change until he should come to her, as he planned to do within a few months. The tension grew greater, and Mabel, in her desire for freedom, began to annoy her father with frequent night letters on the subject. At this point, she chanced to meet on the street a man whom she knew but slightly, to whom she had been introduced in a distant city some months previously. She accepted an invitation to lunch, and proceeded to pour out her troubles to him as if he had been the wished-for father. As a way out of her difficulties, he suggested that she marry him. The suggestion was followed up by two weeks of strenuous courting, and Mabel finally consented, with the proviso, however, that they should not live together as man and wife until she should go to him voluntarily. This seemed to her but fair to her father, to defy whom she was entering the holy bonds of matrimony. Feeling, later on, that in her father's eyes her husband would seem

an inferior person, she was ashamed of what she had done and saw to it that her husband and father never met in the five years that the latter lived.

The first weeks of the marriage were full of terror for her. Her husband became impatient at what he termed her childishness, never having doubted that a satisfactory adjustment would soon be effected. Any attempt of his to overcome her resistance resulted in unspeakable horror on her part, which grew to such proportions that her knees never failed to tremble in his presence, and like *Sue* in Thomas Hardy's book, *Jude the Obscure,* who had a similar feeling for her husband, she once nearly jumped from a window to escape him. The following is one of several verses in which she describes her feeling for him:

> Have you ever panted through miserable moments
> Waiting for a closed door to open,
> A heavy voice to greet you,
> Dreaded arms to clutch you in their tenacious grasp
> And unclean lips demand a warm salute;
> And then sank into an abysmal stupor,
> Your tense flesh creeping with loathing,
> Your mind whirling with hate,
> Your heart a leadened void,
> And wondered why in God's name
> Your quivering soul lived on!

It should be said here that her husband was a man who had met with success with many women, several of whom he had married. Although she did not realize it, he was known as a "confidence man" and through cleverness had escaped prison sentences. She believes now that had he been a more æsthetic type, she might have overcome the resistance of her oversensitive and undeveloped nature, although at the time she felt that she was prevented from accepting her husband's affection because of her feeling of loyalty to her father.

With her imaginative nature, she had always looked forward to marriage and all that it had meant to her: a home and children—both according to story-book ideals, requiring no care and causing no pain—and the affectionate companionship of her husband, fathering her always. This latter attitude was so obvious that her husband had said that her relation-

ship to him was that of a child rather than of a wife. Adler* says, in his description of neurotically retained childhood defects, ". . . the fact very frequently comes to light that the patient is very enthusiastic for life, for work, for love and marriage, but platonically, while secretly he bars the access to them through the neurosis, in order to make sure of his domination in the more limited field of the family with the father and mother."

After some emotional episodes with her husband that filled her with terror, Mabel felt that it would never be possible for them to have children. She, therefore, visited an orphan asylum and made all arrangements for the adoption of a child, before consulting her husband. When he was told of her plan, he was vehemently opposed to it, which was natural enough at that time. About the same time, and still during the first months of her married life, a Russian wolfhound, to which she was devoted, died, partly, as she thought, from the results of her husband's maltreatment.

The first shoplifting occurred after these two incidents and continued at varying intervals for the next seven years. After what were to her six years of torture with her husband, she left him. During the succeeding year, she rapidly spent what money she had with a childishness that was characteristic, in spite of knowing that there was no prospect of more from the same source. She attempted, with little success, to become a moving-picture actress, and had finally exhausted her funds when she was arrested for taking a number of things from department stores, which were finally traced by the store detectives. She seldom used the stolen articles—usually clothes—she rarely gave them away, and she never sold them, no matter how great their accumulation became.

This case, which has had a fairly exhaustive analysis, may be classified as a compulsion neurosis. The mental conflict centering about her unadjusted marital relationship was the immediate cause of her antisocial conduct, which more fundamentally represented an effort to gain satisfaction in the expression of her ego by successfully defying authority in the form of the law, as a result of resistance to parental authority

* Adler, Alfred. The Neurotic Constitution. New York: Moffat, Yard, and Company, 1917. p. 96.

as expressed by her father and her husband. This type of compensation is similar to that described by Clark* in cases in which the stealing was the result of antagonism to the father and represented a desire for childish revenge. The antisocial behavior ceased in Clark's cases when a satisfactory adaptation to parental authority was made.

Mabel now realizes that even as a child she had been conscious that she could get anything she wished from her father. She had ruled him absolutely. It was only when the change came which followed his business reverses that she suddenly lost her power over him. His sudden attempt to exert parental authority was intolerable to her. She wanted to be humored and to rule, true to the picture of the neurotic constitution that Adler so well describes. As her father had failed her, she tried to find a substitute, some one who would humor her and whom she could rule in the same way in which she had always ruled him. This man who suggested that she marry him seemed a possible candidate—in other words, a second father. Judging by his courtship attitude, she felt that he would fill such a need. Acting on this estimate of him, she made the stipulation regarding their marital relationship. But after their marriage, her authority again failed. He was unwilling to submit to her will and would not allow her to adopt the child that she longed for, and he tried to insist on a normal relationship between them. This, then, was the immediate cause of her clash with his authority—her inability to obtain by adoption the child that she desired and to make the adjustment that would have given her in a natural way what she most desired, children and the intimacy of a home. She never dared to venture living in an apartment, fearing the enforced intimacy with her husband, but lived always in hotels, maneuvering to find excuses to absent herself from him as much as possible in the intervals between his business trips.

The unexpected emotion that was shown when children were mentioned and the frequency of the child and of the child's cry in her dreams all contributed to increase the significance of the maternal longings in a woman too immature

* Clark, L. Pierce. A Psychologic Study of Stealing in Juvenile Delinquency. *Archives of Neurology and Psychiatry*, Vol. I. pp. 535-546, May, 1919.

and inhibited by what she considered loyalty to her father to make the necessary marital adjustments. In one of her dreams, she attempted to escape the horror of hearing the cry which called and which she could not reach by running away from it, and her sense of satisfaction came to her by defying authority in the form of the law as she ran.

Mabel's immaturity was largely due to her extreme attachment to her father, which resulted in part, at least, from his discouragement of friendships with those of her own age. Once, during her adolescent years, she innocently sent a picture to a youth of her own age. Her father learned of it and made a scene, asking many questions about her customs and those of her girl friends. He forbade the repetition of such a reprehensible thing as exchanging photographs, and discouraged even innocent correspondence. Rebuffs such as this appeared to be sufficient to keep her from forming outside friendships, particularly with the opposite sex, and made her content herself the more with her father's companionship.

The reason that her defiance of authority took the form of shoplifting may perhaps be found in the fact that her first misunderstanding with her father occurred when, as a child, she took some stamps from him, an act which he interpreted as stealing, but which she felt was within her rights. She had always assumed the right of appropriating anything that was his. She had frequently taken for her own use the appointments on his desk and the personal belongings from his room, things that it gave her pleasure to have near her. At no time, however, had she appropriated in the same way anything that belonged to her mother. She never forgave her father for not understanding her point of view regarding the incident of the stealing, for his harsh scolding, and particularly for telling her mother. In other words, this event represented her first collision with authority in which she failed to dominate. She believes that she was never, after this episode, able to express her affection for him as she had done before. Her father often remarked about the change, and said he longed for a fairy wand that would make her the affectionate child she had once been.

During one winter in the seven years of her married life, she was interested in the activities of a man, considerably

older than herself, who lived in the same hotel, but whom she knew only slightly. He was active in social reforms. She enjoyed being of assistance to his secretary at times, although this was unknown to him. During this period of interest, there was no larceny. She begged her husband at the time to allow her to take a secretarial course, but this was denied her. If some such utilization of her energy had then been possible, it would probably have provided a substitute that would have prevented further antisocial conduct. In this interest there was also a strong association with the interests of her father, who had been a literary man.

Writing has a creative element that frequently furnishes a fairly satisfactory sublimation of maternal and paternal instincts. If the husband had ceased to insist upon a normal relationship, and if she could have had a creative outlet through writing, she would probably have fulfilled her childish ideals without the adoption of a child, and the antisocial conduct would not have been indulged in. She herself said that she felt she would not have stolen had she lived on with her father or had she been happily married.

During her sojourn in our hospital,* she became one of our most reliable and efficient workers. Although at first she was unable to thread a needle or do anything of a practical nature, she learned to sew and made many artistic things in the occupational room. She later advanced to the kitchen, where she became a good cook and almost a housekeeper; she could never express enough appreciation for her kitchen experiences. All this time, through the courtesy of one of the laboratory staff, she was studying typewriting and stenography, in which she made good progress. She tried her hand at short-story writing in the hope of earning money to pay her debts, and later began to write verses, which, though not indicative of great literary talent, were invaluable in revealing her mental life and showing the progress of the analysis.

When it was necessary to discontinue our study of her, she was able to return to the main institutional group, where she made contacts of various sorts with other women, which were much to her credit. She became also of considerable help to

* The Psychopathic Hospital of the Laboratory of Social Hygiene in connection with the New York State Reformatory for Women at Bedford Hills, N. Y.

the third patient whom we are to describe. After leaving the institution, she took an office position. She is at present taking a secretarial course two evenings a week, and is rapidly becoming more proficient in stenography and typewriting, as well as in library work, which she enjoys partly because of early associations with her father and partly because of what is probably an innate interest in books. In her dreams, books and libraries occurred frequently and were apparently a source of much satisfaction to her. The satisfaction gained through similar work, even though there was little of it, during the winter previously mentioned when she was not tempted to steal, is additional evidence of the wisdom of this choice of literary occupation.

It may be of interest to add that this patient feels that her life would never have amounted to much had it not been for her institutional experience, and she believes that in no other way could she have attained the development and the mental rebirth which she thinks resulted from it. It has sometimes seemed as if she had unconsciously desired the prison experience and sought the reformatory as a way out of her difficulties in the same way that a case of "shell shock" sought the hospital to escape the trenches. She said herself that she felt that only by going to an institution would she be able to escape her husband.

In this case it was possible to reach the deeper emotional levels only after many months. Much time elapsed before complete confidence was gained and superficial resistances overcome. There was sufficient time, however, for a satisfactory reconstruction before the patient left the hospital. When cases of this kind that are capable of reëducation come to our reformatories, it is a pity not to be able to give them the opportunities that are needed to effect their reconstruction.

Case III: Harriet U., aged twenty-four, was sentenced to the reformatory on the charge of petit larceny. Following some incorrigibility and petty stealing for which she had been given probation in the past, she was finally arrested for stealing a hat valued at five dollars from a department store, for which she was given a three years' indeterminate sentence.

Because of her erratic behavior before entering the institu-

tion, in staying away from home, lying, stealing, and being generally unmanageable, and because in the institution she had great difficulty in adapting herself to the regulations and acted with a childishness that seemed incompatible with her good mentality and general appearance of womanliness and poise, she was transferred to our hospital for special study and treatment. The struggle that Harriet went through in her effort to coöperate with us and help us to find the cause of her emotional resistance was pitiful. On the one hand was her desire to talk about the tangle of her life and face her difficulties in order to make good and prove her affection for those who were trying to help her; on the other hand, as deterring factors, were the sense of shame for her past, the dread of admitting her guilt, and the fear of incriminating another person whom she loved.

After this struggle had continued for several months and when it was too late to continue the treatment further, the following history was disclosed just before she left the hospital. Her father, who was said to have been alcoholic and a ne'er-do-well, had married her mother after she had converted him to Catholicism. Harriet believed that her mother married him because of her pride in his conversion rather than for real love of him. Later, when he lost interest in the church and did little toward the family's support, the wife's ardor cooled and she would have separated from him had it not been for Harriet's passionate affection for him. At a time when he was not living with the family during Harriet's childhood, he used to come to the house to see his daughter. She would cling to him and refuse to let him go, making such a disturbance that it was difficult for him to get away.

It was in her relationship with her father—she is apparently not clear in her own mind as to what actually happened —that her sex consciousness was aroused, which resulted in the most profound sense of guilt regarding their relationship. This dated from her seventh year. From that time on, Harriet could not bring herself to talk of it to any one because she feared to incriminate him. Her sense of guilt made her shun everything of a sex nature to such an extent that she was wholly ignorant of the simplest physiology; even an enema was to her a form of assault. She could not submit to it. Her

dread extended also to a variety of physical things. Atropine dropped into her eyes caused an intense emotional reaction. She could with the greatest difficulty submit to dental treatment, even when it did not cause pain.

For years she had avoided expression of affection in every form because of the sense of shame that was connected with the expression of affection in her childhood. As a result of this, even the most desirable of suitors had been kept at a distance. She knew that a certain man wanted to tell her how much he cared for her and ask her to marry him, but she could not bear to have him do so. When he urged her to spend the evening at home, so that they might talk, she insisted upon going out to the movies or to a dance. She preferred anything that would prevent him from touching her deep-repressed emotions. After she had brought herself to talk with us about her early life, her attitude toward the question of marriage changed and she felt that should another such situation occur in her life, she would no longer dread it, but would be able to allow the real affection that she felt to come to the surface. The nearest approach to a direct expression of her feelings had been in competitive dancing, which she loved, but which she would never talk about because she associated it with the forbidden regions of her emotional life and was consequently ashamed of it.

As she looked back on her life, it seemed a series of might-have-beens and feelings of remorse. She felt that she had appreciated situations only when it was too late to remedy them. Her mother died when Harriet was seventeen or eighteen years old, a year after the father's death, and Harriet had never ceased to grieve actively for her mother. On studying into the nature of this grief that had persisted obsessively for six years, it was found that it was not so much sorrow for her mother's death, because her mother had suffered greatly during her life and was glad when the release came, but it was a sense of remorse at the unhappiness she had caused her mother by her extreme affection for her father, a condition which she recognized only when it was too late to make up for it in any way. Her aunt had pointed out to her that she had been the source of much unhappiness to her mother, for had it not been for her affection for her father,

her parents would have separated permanently, and this would have relieved her mother of much sorrow. The intensity of Harriet's sense of remorse about her mother was caused by her feeling of guilt connected with her relationship with her father.

It was always when she was worrying intensely about her mother and longing for her that she stole. She remembered that in the past she had been in the habit of stealing from her mother, although this had never been discovered. She never stole, however, from her father. She thought that in some way the cause of her stealing lay in the sense of guilt that had caused her to deny to her deeper emotions and her longing for affection any normal outlets. She felt the connection, but she could not explain it. It was as if the stealing were a vicarious expression of her repressed emotion; it might be termed an illusion of compensation. Much of her antisocial conduct that expressed itself by defying her aunt, with whom she lived, and either refusing to tell where she had been—although what she had been doing had been quite innocent—or lying about it, were all attempts to protect the inner turmoil of her life from the interference of outsiders. They were, in other words, defense reactions.

Harriet asked with a great deal of emotion if the early experience had really been as terrible as she had always supposed. It had seemed to her so unfair to tell, or even to intimate, this thing about her own father. She was tremendously relieved to be told that she was too young at the time to be held responsible and that one could hardly blame the father for what had happened, since so little was known of him and of the general situation. This simple reassurance relieved her of the intolerable feeling of oppression from which she had suffered for a period of fourteen years, and she felt that now she could unearth the emotion she had been repressing with such tragic results and learn to express it in her everyday life by projecting her interest into the lives of those with whom she came in contact. In this way she could learn in time to direct her energy along constructive lines away from herself. In the past it had taken the path that turned inward and had ended against an impassable wall that shattered it as an entity and a constructive element, and forced a part of it,

at least, to seek by-paths that constituted her illusion of compensation.

With this patient, many months were consumed in simply approaching the conscious emotional experiences of childhood. In spite of the greatest effort at coöperation and sincere protestation of confidence on her part, it was impossible for her to overcome her resistances until it was too late for us to accomplish anything with her in the way of reëducation. The conflict that she went through before leaving the hospital was intensified as she remembered that if she could not bring herself to talk, she would have one more regret to add to the already long list of might-have-beens. The thought was almost more than she could bear.

Although she gained a temporary relief from the point of view that it was possible to give her at that time, there was still so much readjustment required in her life, on the basis of the new foundation, that it is not strange that without further individual treatment the process of reconstruction did not continue long without regressions. Although she responded well at first to her new environment, after a while she lapsed into the old habits of antisocial behavior, and as a result lost, for a time at least, all signs of ambition. She stole and lied to such an extent that it was necessary to remove her from the position of responsibility which had been given her. Furthermore, she formed a strongly emotional and undesirable attachment for a young woman who had kept a house of ill fame. Harriet had never been sexually delinquent, although there had been much opportunity and she had spent many nights sleeping in hallways. The experience of her seventh year was a safeguard against this, as well as being the apparent cause of her many difficulties.

Recently, due perhaps to a brief continuation of the former analysis, Harriet has made a fresh start with a renewal of courage which she seemed to have lost in consequence of her inability to take advantage of the opportunities that were offered her. She need not have been discouraged, however, as her life habits were too deeply rooted to be dislodged in so short a time. Still, much relief has already been obtained by having some light thrown on the "horrors" of her past, and difficult as her readjustment will be, it can hardly cause her

as much suffering as resulted from the intense feelings of remorse that were associated with the memory of her early experiences. We believe that a satisfactory adjustment of her life should, under suitable treatment, be wholly possible.

This case is similar to those described by Healy* in which the stealing was the result of a mental conflict. There is no evidence in our case, however, that the knowledge of sex and of stealing were acquired at the same time to account for their close relationship.

Harriet's case resembles that of Mabel in the compulsive nature of the stealing, which in each instance apparently resulted from a conflict of emotions. In Mabel's case, the conflict arose directly from a genuine situation which was going on at the time, although it was based on developmental conditions of a much earlier period, her early injudicious training. In the last case, however, there was no actual situation in the present that was intolerable. Her conflict lay in the obsessive thoughts that were based on actual situations in the past, her experiences with her father. The first case cited also revealed this latter condition, and her conflict resulted from obsessive ideas regarding a past situation—her experiences with her teacher—rather than from a situation that was intolerable at the time.

In the last two cases no physical condition was found that would have a bearing on the antisocial conduct. Both are well-developed and well-nourished individuals. Moreover, their intellectual capacity, as has already been stated, is well above the average.

Summary

The three cases represent, we believe, attempts to compensate for emotional repression, which had been associated with a distressing mental conflict.

In the first case, there was an internal fermentation, which bubbled over in an antisocial way when the patient, because of an unusual strain in her environment that made her past more oppressive than usual, was unable to obtain an emotional outlet and feeling of compensation through her religion. Had it not been for her mental conflict during sixteen years, she

* Healy, William. Mental Conflicts and Misconduct. Boston: Little, Brown and Company, 1917.

would not, we believe, have become delinquent in the eyes of the law. There seems little probability now of her delinquency being repeated. That she chose the outlet she did instead of others apparently resulted from the fact that this particular act typified to her the worst thing she could do and represented an attempt to win back favor and effect a reconciliation. The sex avenues were blocked on account of her fear and sense of shame. No associations could be ascertained in our brief study to explain why the stealing of a hand bag was to her such a terrible thing. Some more definite relationship, however, may be revealed later on. The interesting characteristic of this case was her ready accessibility and her quick response to treatment. Those who have worked and struggled with delinquents of the institutional type will appreciate finding a patient with whom so much could be accomplished in two interviews.

In the second case, the actual conflict centered about her married life—that is, her difficulty in adjusting herself to marital conditions and her inability to obtain children by adoption. The reason for suddenly making the decision that launched her into the predicament of her marriage was a conflict with the authority of her father which resulted largely from the unwise training that had allowed her almost supreme mastery during childhood, and from her excessive dependence on her father. When, at the age of eighteen, she suddenly felt her father forcibly exercising his authority, the situation was intolerable to her and she took the quickest way out, regardless of consequences. Her inability to become eventually reconciled to her husband resulted partly from her dream-world habits, which had prevented her from making satisfactory contacts with reality, and partly from rebuffs that her emotions had had at various times in her development which prevented them from seeking expression in an adult way and repressed them to a lower level in a filial relationship with her father that had become wholly satisfying to her up to the time of his business reverses, and with which she had made up her mind to content herself throughout her whole life.

In the third case, as in the first, emotions had been aroused at an early age in a way with which there was such a strong

association of shame that everything even remotely associated with the sexual sphere had in consequence been repressed. The energy that had been repressed as a result of the conflict had expressed itself antisocially in several ways, one of which was stealing. The outlets that she chose seemed to furnish her in some way with what we have called an illusion of compensation. Whether or not the early stealing from the mother was a factor in directing the energy that was seeking vicarious outlet, it was not possible to determine in the limited time remaining after the conscious emotional levels were reached. The future analysis and development of the case should be full of interest.

In all three cases, had the mental life been accessible to wise guidance at an earlier period, the antisocial behavior might easily have been prevented. While the court clinic and the institution laboratory can do much to reconstruct the reëducable delinquent, the real opportunity for constructive work is in the community, where a knowledge of the principles of mental hygiene can be spread abroad through the education of the public en masse and through individual contact, so that, among other things, mental conflicts and social maladjustments may be recognized and treated before they cause antisocial conduct and mental abnormalities.

THE PROBLEMS CONFRONTING A PSYCHO-EDUCATIONAL CLINIC IN A LARGE MUNICIPALITY

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IN July, 1906, the Board of Education of the City of St. Louis authorized the establishment of "special schools for individual instruction." Superintendent Soldan, in one of his reports, defined with remarkable perspicuity both the types of children that should and those that should not be assigned to these schools To quote: "The expression 'defective children' does not refer to dull, backward, or slow children who are otherwise normal." "In some cases a child that is apparently mentally defective is not really so, but suffers from physical ailments." "The term 'defective' applies to that child only who is neglected by nature and is constitutionally incapacitated for the ordinary studies. He may possibly advance a little in intellectual work, but there are narrow limits in the quantity and quality of the school work he is liable to do. He may make a little progress in some of the studies and yet be incapable of grasping others. Very often the defective child can be taught the elements of reading, but it takes several years before he has mastered the few pages in the primer and even then his reading may be mechanical only, speaking the words without grasping their meaning." "In not a few cases, special training in a small school, by a skilled teacher who has made such work a specialty, may advance the defective child sufficiently to enable him, when he leaves school, to do some useful work in life and to fill some humble economic position." "It is evident that admission to the special schools must be very carefully scrutinized and controlled." "The backward or slow child of otherwise

* For further details with regard to the work of the clinic, see Problems of Subnormality. By J. E. Wallace Wallin. Yonkers: The World Book Company, 1917. See also Reports of the Board of Education of the City of St. Louis since 1914.

normal faculties should not be taken away from the regular school . . . and care must be taken to limit admission to those children who are mentally defective and not merely slow." "No child who can in any way profit sufficiently from instruction in the ordinary schools should be transferred to the special room." On the other hand, "the 'mentally unbalanced' or 'imbecile' or demented children who cannot profit by school instruction at all should not be admitted." They "require the watchful nurture of an asylum." These citations clearly show that the St. Louis special schools were established exclusively for feebleminded children.

In the school year 1907-1908, three such schools were established, with six teachers and a total attendance of one hundred.

As time went on, the educational authorities became convinced that the admissions to these schools should be more carefully supervised and controlled, and as a result the psycho-educational clinic was established in September, 1914. According to the regulations adopted, this clinic was to examine and report upon cases of abnormal children; to have general supervision of the special schools for individual instruction, and to instruct teachers in them and classes at the Harris Teachers' College; and to investigate the needs of and make suggestions on the course of study for abnormal pupils.

A cursory inspection by the writer of the pupils already in the special schools made it plain that the school authorities were correct in their surmise—that many of the pupils in these schools were in no sense mental defectives, but children who were mentally and physically handicapped in various ways, such as speech defectives, paralytics, neurotics or unstables, visual aphasia and dyslexia cases, semi-sighted and semi-hearing children, delinquents and linguistically handicapped children. A very considerable proportion of them were merely backward in general intelligence, while a minor proportion were primarily cases of social and educational neglect. We estimated roughly that from one-third to one-half of these pupils were not feebleminded and therefore not strictly eligible for these schools. The great majority of them would, however, have been misfits in the regular grades. We found only an occasional error of judgment respecting a

pupil's need for special instruction; the mistake lay in the character of the class to which the assignment was made.

For various reasons—among them the limited number of other types of special classes to which pupils could be transferred—it was deemed inadvisable to examine the children already in the special schools with a view to the proper placement of those misassigned. It happened, however, that some parents insisted upon a child's transfer to the grades. In such cases examinations were made to satisfy the parents. Some of these children, we found, had been properly assigned, but many had not. A number of the latter, whom we were able to transfer to ungraded or regular classes, are now doing satisfactory work in the upper elementary grades or in the high school. We are convinced that many of these children, if retained in the special schools, would never have gone beyond the third, fourth, or fifth grade in literary studies, partly because their progress would have been impeded by the slow pace of their feebleminded mates, partly because a teacher who has devoted her time to teaching feebleminded children for a number of years has been out of touch with the instruction in the upper grades and is not competent to undertake it, and partly because they would have received considerably less instruction in the literary branches in the special schools. Certainly, as soon as the schools begin to differentiate instruction for the various types of misfit children—and the necessity for doing this is just as imperative as the need for differentiating medical treatment for the various types of patients in hospitals—no measure will be more important than that of providing for satisfactory diagnoses of the children's disabilities, since a differentiated instruction unsuited to a child's peculiar needs may be more detrimental than the ordinary instruction, while it withholds the positive benefits that would result from properly prescribed work.* Nor are the disadvantages limited merely to subjecting the child to a maladjusted program. It is regrettably true that assignment to a special school for the feebleminded may

* We have frequently seen the truth of this statement exemplified in the case of non-feebleminded speech defectives and dyslexia pupils who have been assigned to classes for mental defectives. We have hitherto on numerous occasions deplored the fact that so many non-feebleminded children have been assigned to classes for the feebleminded.

close the door of opportunity to a child who is not feeble-minded, since a diagnosis once made is likely to follow an individual through life. In the bill—now enacted into a law—which we drew for the Missouri Children's Code Commission, registration in the classes for subnormals is limited to feeble-minded children. In New Jersey and New York, children mentally retarded three or more years may be assigned to the same classes.

In this matter of making adequate differentiations of unusual pupils, we should like to emphasize the necessity of employing examiners who have extensive first-hand experience of the various types of mentally abnormal pupils. The assumption that any psychologist or physician is fully competent to undertake this task, if he has had experience in testing groups by the army intelligence tests or individuals by the Binet scale, is fraught with grave danger to the individual pupils. The problems of mental and educational diagnosis are often so obscure as to baffle experts, let alone amateurs.

The situation that we found in the special schools has, moreover, given rise to various difficulties with which the psycho-educational clinic has had to wrestle from the time it was established. For the benefit of communities that are following the St. Louis procedure in the development of special types of instruction, and that will unquestionably be confronted with the same problems, it seems advisable to recount these difficulties, to emphasize the importance of providing the machinery for securing a correct selection of pupils when the special classes are first organized, instead of waiting several years and then taking steps to rectify mistakes that should never have been committed. Teachers attending my courses of instruction during the last decade have frequently called attention to exactly the same difficulties in their own schools. It is well for mental hygienists to be aware of the obstacles that confront us in this work.

We soon found in our St. Louis work that many principals referred absolutely all kinds of abnormal—and even normal—children for assignment to the special schools for the feeble-minded. On inquiry, some principals explained that they were the types of children who had been previously trans-

ferred. When the director of the clinic, acting under definite board regulations and specific instructions from the superintendent, did not assign some pupils to the special schools, but recommended their transfer to other types of classes which had not been established by the schools, thus returning the child to his old class, many principals were inclined to regard the clinic as an obstructive barrier, because it put them to the trouble of securing the filling in of rather elaborate reports on children who, after all, could not be placed, and because it interfered with their former prerogative of practically making the diagnoses and assignments themselves; for many principals have stated to the writer that no child whom they had ever recommended to the special schools had been refused transfer. In the circumstances, it is not at all surprising that the membership of the classes consisted of a conglomeration of all types of mental, educational, moral, and physical misfits. Naturally, some principals whose recommendations for transfer to the special schools had formerly been invariably carried out, and who were apparently more interested in securing the removal of the child from the regular grade than in securing his placement in just the type of class in which the instruction would meet his specific needs, felt that they were making less headway under the clinic than under the easy procedure formerly in vogue. Evidently it was of minor consequence that the regulations explicitly provided that only mentally defective children should be admitted to these schools.[1] Had special classes been available for other types of abnormal children, this difficulty would probably not have arisen, although there are principals, especially of the old school, who still insist that they are quite competent to classify all their pupils psychologically and educationally.

The extent to which children other than feebleminded were referred to the clinic for assignment to the special schools may be gathered from our annual tabulations.[2] Of the whole number referred, the percentages diagnosed as feebleminded were as follows: in 1914-1915, 29.5; in 1915-1916, 30.8; in 1916-1917,

[1] It should in fairness be said that principals have reported that oral instructions were given them which were at variance with the board regulations.

[2] In order to avoid any unjustifiable deductions, it should be explained that some of the children were referred for other reasons than suspected feeblemindedness; but such cases were not very numerous.

27.8; in 1917-1918, 36.6; and in 1918-1919, 33.8. The percentages recommended for assignment to or retention in the special schools for mental defectives for the same years were as follows: 38.8, 39.8, 30.8, 53.5, and 42.8.* During the first three years, the initial selections were made by the principals. In this period, the per cent classified as feebleminded did not exceed 30.8, while the per cent assigned to the special schools did not exceed 39.8. The largest percentage of feebleminded in these first three years was found in 1915-1916. This was due to the fact that the clinic that year was authorized to make a registration of all children pedagogically retarded two years or more, and to examine the most backward of these. This increased the percentage of feebleminded and border-line cases about 15 per cent. It will be noted that there is an increase in the ratio of mental defectives in the last two years, after the clinic had been given the initiative in the selection of examinees.

The intelligence diagnoses of the pupils assigned to the special schools is shown in Table I.

TABLE I

Intelligence Diagnoses of Pupils Assigned to Special Schools for Mental Defectives

	Total	Imbeciles	Morons	Border Line	Backward	Retarded	Deferred
1914–15	157	13	52	42	38	2	10
1915–16	170	19	75	37	17	0	20[1]
1916–17	144	33	53[2]	54[3]	1	0	3
1917–18	171	30	67[4]	70[5]	4	0	0
1918–19	117	9	69[6]	36[7]	1	0	2

1. Two normals, one disciplinary boy, and one epileptic girl.
2. Includes 28 potential morons.
3. Includes 45 potential feebleminded.
4. Includes 26 potential morons.
5. Includes 42 potential feebleminded.
6. Includes 33 potential morons.
7. Includes 17 potential feebleminded.

* The difference between the number diagnosed as feebleminded and the number assigned to the special schools is not necessarily an exact index of the excess of non-feebleminded children assigned, because of the operation of various disturbing factors. For example, some feebleminded children were not assigned because they were too low mentally—we used to accept no mental defectives with a mentality of less than V-years, except on probation—or because they could not get to the schools or their parents refused to enter them.

The reason why so many pupils who graded above border line were assigned during the first two years was partly because of the urgent request of their principals that they be transferred from the regular classes and partly because of the impossibility of keeping up the attendance in the special schools. In spite of the fact that the clinic was constantly examining candidates for these schools, the enrollment declined after 1913-1914, as shown in Table II. In that year there were 31 teachers, while in the following two years the number dropped to 29, the next year to 27, and the following two years to 25. The total registration during this period declined from 600 to 457.

TABLE II

The Number of Teachers and Total Enrollment of Pupils in the St. Louis Special Schools for Mental Defectives

Year	Number of Schools	Average Daily Attendance	Total Registration	Number of Teachers
1907–08	3	84	100	6
1908–09	6	148	223	12
1909–10	7	203	303	17
1910–11	9	264	396	22
1911–12	11	307	467	26
1912–13	13	341	529	29
1913–14	13	380	600	31
1914–15	12	326	529	29
1915–16	12	320	484	29
1916–17	12	308	434	27
1917–18	11	297	471	25
1918–19	11	296	457	25

The chief reason for the drop in the enrollment is, as already indicated, the sharper differentiation of the pupils made by the clinic. We do not anticipate any further reduction in the enrollment of the special classes. On the contrary, as the city increases in population, the number will probably increase. Moreover, the shrinkage in the enrollment in the special schools has been more than made up by the enrollment in the ungraded classes that have been established. These classes have increased from about fifteen at the time the clinic was established* to fifty-four in 1918-1919, with a total registra-

* Most of these were "finishing classes" of the Mannheim type for older redardates about to leave school, rather than ungraded classes.

tion of part-time and whole-time pupils in 1916-1917, the last year for which we have the complete data, of 3,111—3.4 per cent of the elementary registration at the end of the third quarter in 1917—of whom 1,317, or 42 per cent, were reported as restored to grade.

In spite of the significant increase in the number of these ungraded classes, we estimate that we have now only about half as many of them as are needed to provide for all the children of the ungraded type—namely, the border-line, backward, and restoration cases.[1] The chief obstacle toward securing an adequate number of ungraded classes has been the inability to find rooms in which to place them. Another difficulty has been to convince some of the principals of the advantages of such classes.

During the period since the establishment of the clinic, the classes for truant and troublesome boys have increased from one to four,[2] speech-correction work on a very small scale has been started in the school for the deaf, while the facilities of the open-air school have been materially increased,[3] but the extension of the existing facilities, or the establishment of other types of special classes for other types of mentally and educationally handicapped children, which the clinic has repeatedly urged, has been thwarted by the impossibility of securing the necessary appropriations. St. Louis is far more generous in the care of its feebleminded, border-line, and backward school children than the average city of its class in this country, but it has merely made a beginning in the development of some of the other types of special classes. One of our Children's Code measures enacted this year will require the establishment of special classes for the blind and deaf—as well as the feebleminded—whenever there are in a school

1 In 1915, our St. Louis Committee on Special Schools recommended that border-line pupils be assigned to the special schools for mental defectives when circumstances render this necessary—especially the lack of ungraded classes. If possible, only those border-line cases should be assigned who show strong tendency toward feeblemindedness or those who are in their younger years, when they can be properly served by the special-school curriculum. The latter cases should be re-assigned to ungraded classes as soon as such are available.

2 There were five at one time, but one had to be given up because the principals did not recommend enough boys for transfer.

3 The blind children are accommodated in the state school, located in St. Louis.

district ten or more children with these types of disabilities. Moreover, these pupils are required to attend school when special classes have been established.

Aside from the lack of special classes adapted to the requirements of various types of educational misfits, the most serious obstacle confronting the clinic has been the difficulty of routing out the mental defectives in certain schools in which the principals, who were charged with taking the initiative in the selection of the cases for examination, have failed to file reports. During the first year of the clinic, 31 per cent of the elementary schools did not report a single child for examination, while in the next two years the percentages were 21.1 and 15.1. The increase, during the second and third years, of the schools that made reports was due primarily to the fact that toward the close of the second year the clinic was authorized to select for examination the most backward children found in our survey of pupils retarded over two years in the elementary grades. Also, the superintendent, during the following year, in a special circular and again at a special conference, emphasized the announcement that all principals of elementary schools, without exception, would be required to survey their schools carefully and report all suspected mental defectives to the clinic for examination. Even then several of the principals reported that there were no mental defectives in their schools.

Before the establishment of the clinic, no official records had been kept of the schools that failed to recommend pupils for the special schools; each principal had been permitted to handle the matter practically as he saw fit. We learned from teachers in the special schools, however, that most of the principals who were inactive after the clinic was established never, or only very rarely, had recommended any pupils for the special schools. The chief reasons for the disinclination of some principals to report pupils seem to be, first, the conviction that they have no mentally defective children in their schools; second, the fear of arousing the antagonism of parents; and, third, the belief that the children are better off in the regular grades, on the mistaken assumption that they will be stimulated by the normal pupils to put forth better efforts and that they will escape the mortifying feeling of

social and educational inferiority that results from segregation in a special school or a special class. Unfortunately, practically all the published reports from other schools are silent on the question of this most serious obstacle to the development of special schools throughout the country, although there can be no doubt that the same difficulty obtains elsewhere, as is evidenced by numerous personal reports made by teachers from other school systems.* Published data are available for one year from our largest public-school system. During this year about half of the elementary schools in New York City did not report a single child for the ungraded classes. This is a much worse condition than obtained in St. Louis five years ago.

Mainly because of this difficulty of getting at the mental defectives in some schools, the selection of the cases for examination was transferred to the director of the clinic in September, 1917. It was recognized as inconsistent and unjust to hold the director of the clinic responsible for locating the mental defectives without giving him the necessary authority to ferret them out. Since it was out of the question for him to inspect every child with a possible mental defect in the schools, the following plan was adopted:

Every elementary school is required to report every year, on a small blank, the 1 per cent of its pupils who are the most seriously backward or deficient in intelligence.

"The names of one-half this number—that is, one-half of 1 per cent of the pupils enrolled—are to be submitted before the end of the first quarter, and the other one-half of 1 per cent at the beginning of the third quarter. In other words, an elementary school with an enrollment of 1,000 pupils will submit five names during the first quarter, and five names at the beginning of the third quarter.

"In submitting these names to the clinic, the principal should be guided by the following considerations:

"(1) The pupils selected should represent the quota among all the pupils who appear to be the *most deficient in native mental capacity.*

* Recently a teacher stated that one reason for the same difficulty in a large Middle-west city in which she was employed was the fear on the part of some principals that their schools would drop to a lower classification—which would mean a reduction of the principal's salary—if too many children were transferred.

"(2) In estimating the relative degree of mental deficiency or backwardness, consideration should be given to the following details:

"(a) The general mental reactions and behavior of the pupil as observed in his adjustments on the playground and in the classroom.

"(b) The age of the child, the total amount of time that the child has been in all schools, and the amount of progress made in the school work during this period, said progress being gauged by the work which the child is actually able to do rather than by the grade in which he happens to be classified.

"(c) The various factors other than lack of mental ability which may have contributed to the child's backwardness in the school work, such as very irregular attendance, serious or exhausting illnesses, poor comprehension of English because of foreign parentage, etc.

"In estimating whether an older child is a proper candidate for a special school for mental defectives, it is well to bear in mind that a feebleminded child rarely reaches a mentality equal to that of a normal ten-year child, and only rarely is he able to do satisfactory third-grade work, except possibly in one or two branches."

From these reports the director of the clinic selects for examination the pupils who, from the data submitted, seem to be the most backward or the most likely candidates for a special school.

There can be no question as to the pronounced superiority of this method as compared with that previously followed. If the regulations are properly observed, every elementary school will be systematically surveyed twice a year, while a larger proportion of the lowest grade pupils will be selected for examination.*

* This is shown by the percentages of mental defectives given on pp. 107-108. The largest percentages of mental defectives have been secured since the clinic has been given the initiative in the selection of the examinees. The contrast between the figures of the first three years and the last two becomes much greater if we combine the feebleminded and border-line groups, in which we include the potential feebleminded. The per cents for each successive year are as follows: 40.8, 43.7, 59.0, 75.3, and 72.6. The increase in the quota of feebleminded and border-line cases found during the last two years ranges from 15 to 30 per cent. Many of these mental defectives came from schools which had rarely or never before referred pupils for examination, and some of which had especially emphasized the point that they had no mental defectives.

Unfortunately even this method has its drawbacks. Some principals will not file the initial reports unless pressure is brought to bear from the administration. Some fail to supply the more complete data required by the clinic after a child has been designated for examination, thus frustrating the attempt to examine the child. Others, again, do not make a point of seeing that the child keeps the clinic appointment. Sometimes, of course, the principals are not to blame, since parents may refuse to have the child examined or fail to keep the clinic appointment, or the child may be transferred to a parochial school, etc. Nevertheless the records show that some principals habitually fail to supply the data or to have the child report for examination while others almost always see to it that their cases are examined.

Another difficulty incident to the present method of selection is that the preliminary surveys made in some schools are not sufficiently extensive or thorough and in consequence the most deficient children may not be reported. In most cases the reports of the principals are based largely upon the reports made by the teachers. An enthusiastic teacher may report entirely too many pupils, while an indifferent one, with pupils equally deficient or more so, may not report at all. It has happened that all the pupils reported from a school have come from only one or two rooms.

We doubt very much, however, whether it is possible to devise any method of routing out the mental defectives in a large school that will be wholly free from imperfections. But the method we are now using is the most effective we have ever employed and deserves a thorough trial in other school systems where many of the mental defectives escape detection.*

Diagnoses of Cases Examined

The diagnoses of the children examined in the clinic during the five years of its existence are given in Table III. Cases of the children not in the schools are not included—with very few exceptions—nor are privately examined cases. The supplementary diagnoses are incomplete in that no microcephalic,

* The use of group intelligence tests for rough preliminary surveys may offer some additional aid, after they have been made available for use with children of from five to nine years in mental development.

macrocephalic, hydrocephalic, infantile paralysis, cerebrospinal meningitis, or paralytic cases have been tabulated, although notation has been made of all these types on the individual records. In the case of reëxamined children, the final diagnosis has been used.

TABLE III

Intelligence Diagnoses of 1,965 Consecutive School Cases Examined from September, 1914, to June, 1919

	Total		Boys		Girls	
	No.	Per cent [1]	No.	Per cent [2]	No.	Per cent [3]
Normal	68	3.4	56	3.9	12	2.1
Retarded	101	5.0	83	5.8	18	3.1
Backward	567	28.3	449	31.4	118	20.0
Border-line[4]	522	26.1	382	27.1	140	24.7
Diagnosis deferred	87	4.3	57	4.0	30	5.3
Mentality undetermined.	6	0.3	4	0.2	2	0.3
Morons[5]	371	18.5	231	16.4	140	24.7
Imbeciles	235	11.7	134	9.5	101	17.8
Idiots	8	0.4	5	0.3	3	0.5
Total feebleminded	614	30.7	370	26.2	244	41.3
Supplementary Diagnoses—Special Types						
Speech defectives	362	18.1[1]	266	18.88[2]	96	16.99[3]
Delinquents	350	17.5	307	21.79	43	7.61
Visual aphasia	16	0.81	14	0.99	2	0.34
Dyslexia	71	3.61	66	4.71	5	0.85
Visual aphasia and dyslexia	87	4.42	80	5.70	7	1.19
Epileptics	29	1.45	18	1.28	11	1.87
Psychopathic	18	0.90	11	0.78	7	1.19
Unstable and neurotic	116	5.8	85	6.03	31	5.48
Mongolians	16	0.81	7	0.49	9	1.59
Cretins	5	0.25	2	0.14	33	0.53

1. Based on the total number of boys and girls (1,965).
2. Based on the total number of boys (1,401).
3. Based on the total number of girls (564).
4. Includes 54 boys and 24 girls diagnosed as potential feebleminded since September, 1917.
5. Includes 35 boys and 29 girls diagnosed as potential morons since September, 1917.

This tabulation is unique in that the psychological examinations have all been made by the same examiner over a longer period than that covered by any tabulation thus far published —so far as is known to the writer— of institutional or school cases classified from the standpoint of intelligence level and

of associated disabilities. Since the children examined came from a large representative American city, the conclusions drawn have a vital bearing upon many moot questions in the field of social and psychological diagnosis. During the last decade a multitude of psychological surveys of retarded children in the schools have been published, but these surveys have almost always been based merely upon a Binet-Simon test conducted during a period of a few weeks. In our St. Louis examinations, we gathered data—all of which were duly weighed before a diagnosis was made—from the following sources on practically every child examined: a fairly thorough physical examination made by one of our inspectors of hygiene; development, hereditary, and environmental facts, gathered for the most part by the school nurses and physicians, assisted by attendance officers, teachers, principals, and the director; the pedagogical history, supplied by the school staff; the psychological examination;[1] and the psychological observation of the case during the examination and frequently later in the special school.

During the five-year period, we have, as the table shows, identified 614 feebleminded children in the St. Louis public schools.[2] In other words, only about one-third of those sent to the clinic for examination on the presumption that they were feebleminded were actually so diagnosed. Even if we add the border-line group to the feebleminded—an aggregation of 1,136—the proportion is still only 56.8 per cent of the total number examined.

On the basis of this five-year finding, what conclusion is justified regarding the prevalence of feeblemindedness among the children in the public elementary schools of St. Louis? It is difficult to answer this question accurately because, from the school statistics available, it is not possible to determine the total number of different pupils who have attended the schools during this period. All we can hope to do is to make a rough estimate of the total registration. If we place this

1 This included the Binet-Simon tests, various tests of psycho-motor capacity, sometimes other psychological and educational tests, and anthropometric tests, used invariably during the first two years, but only occasionally since, because of lack of time.

2 A few of these, however, came from the parochial schools.

figure at 120,000, the ratio of mental defectives would be one-half of 1 per cent.

This estimate is in harmony with the estimates made in the three largest American cities—New York, Chicago, and Philadelphia, where the problem of mental deficiency has been studied intensively for many years—and with many of the European studies. On the other hand, it is in sharp contrast to the conclusion, frequently drawn from cursory surveys based upon a few weeks' Binet-Simon testing, that from 2 to 3 per cent—or even 4 per cent—of the children in our elementary schools are feebleminded. The writer is satisfied, from his observation of children assigned to the special schools in many large American cities, that the proportion of mental defectives in the large school systems does not differ materially from the ratio found in New York, Chicago, Philadelphia, and St. Louis, our four largest cities.

There are a few American writers who consider our standard of mental deficiency too low. These writers contend that a person who does not develop beyond XII-years by the Binet-Simon scale is feebleminded,* while we have placed the limit somewhere near the Xth-year, which accords substantially with the conclusions reached by Binet and Simon among the French and by many British and American writers. That we have not been overconservative has, we believe, now been demonstrated by the examination of 1,750,000 soldiers of our selective draft. If the average intelligence age of these men is 13.2 years, as reported, and if this represents the intelligence age of the average American citizen—as has been affirmed by a writer who has persistently defended the XII-year standard of feeblemindedness and called it "conservative"—is it not sheer folly to continue to fix the upper threshold of mental deficiency only three-tenths or four-tenths of a year below the average intelligence age? Obviously, the highest level of feeblemindedness must come several years lower. On the basis of the widely followed I. Q. standard of .70, the upper limit would come at 9.2 years, based on the average intelligence age. In point of fact, many men with a

* Most of those who have held to this standard, however, have hedged considerably during the last three or four years, placing the limit below the twelfth or eleventh year.

IX-year mentality were found in the army who could not be classed as feebleminded in the legal and social connotation of the word, which represents its sole legitimate application. After years of follow-up observation of many of our cases, we are of the opinion that we have made just as many errors because of a too high standard of feeblemindedness as because of a too low. We are convinced that not only many pupils assigned to classes for mental defectives, but also many placed in colonies for the feebleminded, are not in fact feebleminded. Many inmates of institutions for mental defectives grade higher in intelligence and pedagogical attainments than some of the subnormals we have examined who are successful at large in society.

If we combine the feebleminded and border-line categories, the proportion of distinctly subnormal children in the St. Louis schools would be .94 per cent of the elementary enrollment, assuming that to be 120,000. If we add the backward and retarded groups, the per cent is 1.5. The latter figure, of course, does not represent all whom we would classify as subnormal, as we have examined only a small proportion of the backward and slightly backward pupils. Were all these cases included, the percentage of subnormals would probably reach from 3 to 5 per cent. On the other hand, those whom we have classed as retarded and some of those classed as backward can be restored to normal. Many have already been reported restored "to grade."

Prevalence of Special Types

Turning now to our supplementary diagnoses in Table III, we find that only .81 of 1 per cent of all the clinic cases—2.6 per cent of the feebleminded cases—were Mongolian defectives or appreciably Mongoloid,* while only .25 per cent of all

* Still classified 22 per cent and Lapage 16 per cent of hospital cases of all grades as Mongols, while Lapage found 6 per cent among cases rejected as too defective and .5 per cent among cases admitted to the Manchester, England, special schools, or 1.1 per cent of all cases. Down classified 10 per cent of "all cases of idiocy" as Mongolians, while Barr found it "occurring in only .09 per cent." The difference in these ratios is probably due primarily to the difference in the relative number of low-grade defectives included in the different surveys.

our examinees were cretins or markedly cretinoid,[1] which is only eight-tenths of 1 per cent of all the feebleminded cases. It is evident that the number of cretins and Mongolians is too small to be of any considerable aid in the diagnosis of public-school mental defectiveness, and the same may be said of the microcephalics, macrocephalics, hydrocephalics, and amaurotics.

The proportion of epileptics among our St. Louis cases—1.45 per cent—is also very small. This may be due to the fact that many low-grade epileptics and epileptics subject to severe attacks were never entered in the schools and consequently were not referred to the clinic.

The proportion classified as psychopathic[2]—.9 per cent of all the examinees, only three or four of whom were so classified by the medical inspectors—is very small considering the proportion of psychopathic constitutions reported by some examiners of delinquents and criminals. Our small ratio is due partly to the fact that the abnormal intellectual, emotional, and motor reactions of many subjects are not sufficiently developed in childhood to justify a positive diagnosis of psychopathy or mental disorder, and partly to the fact that the term psychopathic constitution—with all its equivalent expressions—has not yet been precisely enough defined to be used without ambiguity in diagnosis. Many of the leading psychiatrists do not agree as to what constitutes a psychopathic constitution. The numerous signs and symptoms that are thus diagnosed have by no means the unmistakable character of a positive Klebs-Loeffler or a positive Wassermann. This is undoubtedly the principal reason why some medical examiners report a large percentage of "psychopaths" among delinquents, while others never find a case. The large differences found are probably subjective rather than objective.

It is useless to attempt to minimize the gap in our scientific knowledge in this field. We have here a large, obscure

[1] For hospital cases of all grades, Still's figure is 2.8 per cent and Lapage's 7 per cent, while for rejected applicants for the Birmingham special schools, Lapage's figure is 2 per cent, for those admitted .7 per cent, and for all grades .9 per cent, which is practically the same as our ratio.

[2] We have included in this tabulation a few children who were psychotic, manifesting some of the traits of one of the dementia-praecox syndromes. The psychotic epileptics are not included here.

border-land region, analogous to the border-land zone contiguous to the upper threshold of feeblemindedness. Many individuals manifest occasionally, at one time or another, under different provocations, one or more psychopathic traits in varying degrees. Until this field has been more fully investigated, the examiner who desires to be cautious must employ the concept of psychopathy guardedly, recognizing the tentative nature of many of our conclusions. Thus far almost all of the large percentages of psychopathy have been furnished by examiners holding public positions who are interested in compiling convincing statistics, and not by private practitioners who are more interested in the problems of individual therapy than in statistical compilations, which are impossible without the aid of definite labels and categories.

A much larger proportion of all our cases—5.8 per cent—were classified as neurotic and unstable;[1] while there were more visual aphasia and dyslexia cases—4.42 per cent —than the combined number of Mongolians, cretins, epileptics, and psychopaths. We would call very special attention to the latter finding because, in the dozens of public-school surveys of mental defectives by the Binet-Simon scale, not a single reference, so far as we know, has been made to the condition of word blindness, although we have found that this condition is frequently confused with mental deficiency. We are satisfied that many children who have been diagnosed as mental defectives have been merely word blind.

It is noteworthy that among the thousands of cases that we have examined we have found only one that we could classify as a case of auditory aphasia. We have followed this case for five years and still have doubts as to the diagnosis.

Our largest supplementary groups are the speech defectives and the delinquents, the former constituting 18.1 per cent and the latter 17.5 per cent of all the children examined.[2] We have no data on the number of pupils in the entire school system with delinquent records similar to those of the chil-

[1] As children of the nervously unstable type grow older, their abnormal traits frequently crystallize into fairly definite syndromes or symptom complexes. Some of the children here classified as unstable and neurotic will without doubt eventually become psychotic or justify a diagnosis of psychopathic.

[2] These groups overlap, some pupils being both speech defectives and delinquents.

dren whom we classified as delinquent among our examinees;[1] but in a survey of the entire school system made in October 1915, we found 2,536 speech defectives, which was 2.8 per cent of the entire enrollment at the time, while the percentage in the special schools was 26.3 per cent.[2] In other words, speech defects were six and a half times as frequent among our clinic cases, and over eight times as frequent among the pupils in our special schools at the time of the survey, as among unselected grade children. As we have already explained, some of the pupils who had been assigned to the special schools before the clinic was opened were primarily speech defectives and not mental defectives.

Sex Differences

The percentage of mental defectives among the examined cases was considerably greater for the girls than for the boys, the difference for the morons and the imbeciles amounting to 8.3 per cent each. We have already on several occasions called attention to the fact that the girls we have examined grade lower intellectually than the boys. On the other hand, we have found considerably more mentally defective boys than mentally defective girls in the St. Louis schools—370 as against 244. If we assume that the sexes are equally numerous in our assumed total enrollment of 120,000 for the five-year period—in some years the boys have been slightly more numerous, and in some years the girls—we get a ratio of .61 per cent of mental defectives among the boys and .4 per cent among the girls. Every year more than two-thirds of the pupils in our special schools have been boys. These statistics are in harmony with those of other school examiners[3] and

1 Our delinquents include those who were reported to be truants, thieving, lying, unmanageable in school, vicious, sexually immoral, or manifesting immoral tendencies.

2 In this survey the theory that dextro-sinistrals—naturally left-handed pupils who have been taught to write with the right hand—develop speech defects found little support. In spite of our finding, based upon one of the largest surveys yet made, two recent writers repeat the positive assertion that dextro-sinistrals develop speech defects; one of these presents no evidence, while the other bases the evidence on only a few cases and Ballard's results. But Ballard has been frank enough to state: "I now feel that the subject demands a much more careful and detailed investigation before any very definite conclusion can be arrived at."

3 Treadway, Walter L., and Lundberg, Emma O. Mental Defect in a Rural County (Delaware). Washington: Publication No. 48 of the Children's Bureau, 1919. pp. 27 and 38.

with the fact that there are more males than females in institutions for the feebleminded.

The theory commonly advanced in explanation of this sex difference is that males vary more than females in intelligence —that there are more low-grade, as well as more high-grade, men than women. Some writers, however, maintain that the preponderance of male mental defectives is merely apparent —that the boys are more frequently committed to institutions or referred for assignment to special classes because they are obnoxious and unmanageable, while the girls, being more tractable, are retained at home and permitted to remain in the regular grades.

In order to test the correctness of this explanation, we may compare our data for the first three years, when the initiative in selecting pupils for examination was in the hands of the teachers and principals, with the data for the last two years, when they were selected by the writer purely on the basis of the degree of retardation shown by the school report. The following are the per cents of boys and girls examined each year:

Year	1914–15	1915–16	1916–17	1917–18	1918–19
Boys	74.4	69.2	71.1	70.4	70.2
Girls	25.5	30.4	28.8	29.2	29.5

The percentage of girls examined during the last two years is no higher than during the first three years, although, if we include the pupils selected by the clinic during the last two years who were not examined because of our failure to secure their records or because of parental objections, the ratio of girls is slightly increased—31.1 per cent in 1917-18 and 31.2 per cent in 1918-19.

On the other hand, we obtained a larger percentage of feebleminded girls during the last biennium than during the preceding triennium, as shown by the following figures, which indicate the percentages by which the girls diagnosed as feebleminded exceed the boys so diagnosed among our examinees:

Year	1914–15	1915–16	1916–17	1917–18	1918–19
Per cent.	14.1	14.5	15.7	21.9	27.9

The excess of feebleminded girls in 1917-18, compared with the three preceding years, amounts to at least 6 per cent,

while the excess in 1918-19 amounts to at least 12 per cent. This seems to indicate that the schools had been shielding the feebleminded girls during the first three years. In spite of this fact, however, the absolute number of feebleminded found during the last two years was greater for the boys than for the girls, as shown by the following figures:

	1917–18	1918–19
Boys	69	54
Girls	50	40

The difference between the relative number of boys and girls in the elementary schools is not very significant. We still feel, therefore, that there are more feebleminded males than females, although the evidence is not so conclusive as had been thought to be the case.

All of the special types given in Table III are relatively more numerous among the boys than among the girls, except epileptics, psychopathics, Mongolians, and cretins. The results for the latter classes, however, cannot be considered reliable because of the small number of the cases. During the two years in which the clinic has selected the cases, all of the psychopaths were boys. During the first of these two years, the relative number of epileptics was the same for the two sexes, but the next year all the epileptics were girls. On the other hand, the relative number of cretins and Mongolians remained greater for the girls during this two-year period.

The greatest sex difference is found in the delinquent and word-blind groups. Relatively three times as many boys as girls were reported for examination as having some sort of a delinquent record. However, during the last two years, when the cases for examination were selected by the writer on the basis of the degree of mental deficiency shown by the school report, only about twice as many boys as girls had a delinquent record.

Word blindness was relatively about four times as prevalent among the boys as among the girls. We thus note some tendency of this disability to be sex limited.

In harmony with previous investigations of speech defects, we find that among subnormals relatively more boys than girls have speech defects; but the difference is much less

pronounced than that found among normal pupils in the St. Louis schools. The ratio among the subnormals is 18.8 per cent for the boys to 16.9 per cent for the girls, while among normals the corresponding ratio was 3.6 per cent to 2 per cent. Moreover, during two of our five years, the ratio of speech defectives among our clinic cases was larger for the girls than for the boys, as shown by the following per cents:

Year	1914–15	1915–16	1916–17	1917–18	1918–19
Boys	20.3	12.9	17.1	23.5	19.9
Girls	19.0	17.2	7.6	14.0	26.6

Certainly there is no such sex difference in speech defects among subnormal boys and girls as among normal.

Race Differences

We have tabulated the results of the intelligence diagnoses separately only for the colored pupils (Table IV). The ratio of mental defectives found among these pupils was much higher—about 18 per cent—than among all the pupils in Table III. On the assumption that there have been 10,000 different colored pupils in the elementary grades during the last five years, the ratio of mental defectives among them would be .77 per cent. A number of intelligence surveys have shown that the colored children grade lower than the white in general intelligence, but we need more evidence before we are ready to conclude that the percentage of feeblemindedness is higher among colored children.

TABLE IV

Intelligence Diagnoses of 157 Colored Pupils Examined from September, 1914, to June, 1919

	Total		Boys		Girls	
	No.	Per cent	No.	Per cent	No.	Per cent
Normal	3	1.9	2	1.7	1	2.2
Retarded	8	5.0	6	5.3	2	4.4
Backward	28	17.8	23	20.5	5	11.1
Border line	30	19.1	25	22.2	5	11.1
Reserved	11	7.0	6	5.3	5	11.1
Morons	52	33.0	35	31.2	17	37.7
Imbeciles	25	15.9	15	13.3	10	22.2
Total feebleminded . . .	77	48.9	50	44.6	27	59.9

Intelligence Diagnoses of the Special Types

Four of our cretins were diagnosed as imbeciles and one as an idiot. Our primary concern has been to place these children under thyroid treatment. While wonderful improvement has been reported as a result of the treatment in several of the cases, we have never been able to substantiate this by our tests. In not a single case that we have been able to follow has the thyroid treatment transformed a mental defective into a normal or a merely backward child. In none of these cases, however, was the treatment begun under the age of three years. Had it been begun earlier, possibly the results would have been more favorable. Again, all the mentally defective cretins whom we have examined have been of the lower grades. The thyroid treatment probably gives better results with the high-grade cases.

Let us remark, in this connection, that at least threescore of our St. Louis mental defectives had been diagnosed as glandular cases before coming to our clinic, and for many months and sometimes many years had been given extracts from the various endocrine glands. Every one of these pupils has remained in our special schools, an incurable mental defective. The vast majority of them have shown no permanent mental improvement that could with certainty be ascribed to the glandular extracts, and even those that showed the best results have improved only slightly. The writer has never found any evidence for the glowing reports of the wonderful mental improvement that takes place in mental defectives after the administration of glandular extracts. The cretin is the one recognized type in which the administration of a glandular extract produces mental improvement, but the amount of mental improvement that thus results has, according to our reports, been exaggerated. Much experimental work is still needed with these extracts. In the meantime, it is well not to make exaggerated or hasty predictions.

Fourteen of the Mongolians were diagnosed as imbeciles and two as morons. Many of these had been given glandular extracts without appreciably favorable results.

The figures already supplied (pp. 120-21) show that we found a considerable preponderance of speech defectives among our subnormals. The intelligence diagnoses of the

speech-defective group (Table V) show that many were mentally defective. Forty-eight and two-tenths per cent of our speech defectives were diagnosed as feebleminded; that is, the percentage of mental defectives was much higher—actually 17.5 per cent higher—for the speech-defective group than for the entire group of clinic cases. The preponderence is especially marked among the girls, there being an excess of 24.2 per cent of mental defectives among the girl speech defectives as compared with 15.9 per cent among the boys. The suggestion follows that the reason the preponderance of speech defectives among the boys of our clinic cases was less decided than among the boys of our entire school population was the relatively higher ratio of mental defectives among the girls of our clinic cases—41.3 per cent as compared with 26.2 per cent among the boys.

TABLE V

Intelligence Diagnoses of Speech Defectives

	Total		Boys		Girls	
	No.	Per cent [1]	No.	Per cent [2]	No.	Per cent [3]
Normal	6	1.65	4	1.5	2	2.0
Retarded	14	3.86	12	4.5	2	2.0
Backward	72	19.87	63	23.63	9	9.36
Border line	64	17.65	50	18.76	14	14.56
Reserved	29	8.0	23	8.6	6	6.24
Undetermined	2	0.55	2	0.75	0	0.00
Morons	50	13.8	30	11.25	20	20.8
Imbeciles	117	32.29	77	28.87	40	41.6
Idiots	8	2.2	5	1.88	3	3.1
Total feebleminded	175	48.2	112	42.1	63	65.5

1. Based on 362 boys and girls.
2. Based on 266 boys.
3. Based on 96 girls.

A closer scrutiny of Tables III and V shows that the excess of speech defectives among mental defectives is confined to the imbeciles and idiots. In fact, the proportion of morons was actually 4.7 per cent less among the speech defectives, while the number of imbeciles and idiots was 22.3 per cent greater among the speech defectives than among all the pupils. Properly to interpret these results, let us remark that we have followed a reasonable standard of speech defectiveness. Had we been scrupulously exact, we should undoubtedly

have discovered traces of some speech imperfection in all of the imbeciles. As it is, we have recorded 117 of our 235 imbeciles as speech defectives as against all of our idiots—the best of whom could utter only a few words or monosyllables—and only 50 of our 371 morons. Binet and Simon have emphasized that the idiot "never learns to communicate with his kind by speech," while the imbecile learns to communicate by speech, but not by means of writing.

Almost 80 per cent of the speech defects consisted of defects of articulation, the most frequent type being indistinct articulation, with lisping standing next in order. While the proportion of stutterers was rather small—12.97 per cent—there were more of them than of all the other minor types. There were sixteen cases of congenital motor aphasia or mutism with hearing, all except two among boys. The relative preponderance of indistinct articulation was greater among the girls than among the boys, while only four of the forty-seven stutterers were found among the girls. We found the same excess of stuttering among the normal boys.

TABLE VI

Classification of Speech Defects

	Total		Boys		Girls	
	No.	Per cent [1]	No.	Per cent [2]	No.	Per cent [3]
Indistinct articulation[4] ..	161	44.43	106	39.7	55	57.2
Lisping	119	32.84	88	33.0	31	32.2
Stuttering[5]	47	12.97	43	16.1	4	4.1
Motor aphasia	16	4.4	14	5.2	2	2.0
Idioglossia	8	2.2	6	2.5	2	2.0
Miscellaneous[6]	11	3.0	9	3.3	2	2.0

1. Based on 362 girls and boys.
2. Based on 266 boys.
3. Based on 96 girls.
4. Includes some cases whose speech is almost inarticulate, some whose speech almost borders on idioglossia, and some who can only articulate indistinctly a few words or syllables.
5. Includes the repetition and initial obstruction varieties.
6. Includes cases of slurring, dragging, thick, halting, hesitant or obstructed speech which cannot be subsumed under the other categories.

In contrast with the speech-defective group, we found that the proportion of mental defectives among the delinquents (Table VII) was appreciably less—actually 10.8 per cent less—than among all the examinees.

TABLE VII

Intelligence Diagnoses of Delinquents

	Total		Boys		Girls	
	No.	Per cent [1]	No.	Per cent [2]	No.	Per cent [3]
Normal	23	6.4	21	6.8	2	4.6
Retarded	26	7.4	24	7.8	2	4.6
Backward	143	40.7	136	44.2	7	16.2
Border line	79	22.5	65	21.1	14	32.5
Deferred	9	2.5	7	2.2	2	4.6
Morons	43	12.2	37	12.0	6	13.9
Imbeciles	27	7.6	17	5.5	10	23.2
Total feebleminded	70	19.9	54	17.5	16	37.1

1. Based on 350 boys and girls.
2. Based on 307 boys.
3. Based on 43 girls.

The deficiency of mental defectives was more marked among the girl than among the boy delinquents—8.7 per cent for the boys and 4.2 per cent for the girls. The proportionate amount of deficit of mental defectives among the delinquents was somewhat greater for morons than for imbeciles, amounting to 6 per cent for the former and 5.3 per cent for the latter. It has been constantly and almost universally affirmed that it is the high-grade feebleminded who constitute the chief criminal menace. Miner, however, in one of the most sane and judicious analyses of the data bearing on the relation of mental deficiency and delinquency, concludes that "there is some reason to suppose that, relative to their numbers, the idiots and imbeciles would be more likely to be delinquent than the more intelligent feebleminded, provided none was confined in an institution."[1]

On the other hand, the excesses among our delinquents occur in the more intelligent groups—the normal, retarded, and backward, especially the latter, in which the excess amounts to 11.7 per cent. It is evident that the general average of intelligence of our delinquent group was appreciably higher than the average of all the other groups. To give this fact its proper interpretation, let us recall that the large majority of our clinic cases were selected for examination because of suspected mental deficiency. Had we taken an unselected group of delinquents, the contrast would have been

1 Miner, James Burt. Deficiency and Delinquency. Baltimore: Warrick and York, 1919. p. 217.

even greater. This is proven by our diagnoses of a group of boys assigned to a class for truants. These boys represented the most troublesome pupils enrolled in the schools at that time (1914-1916) with the exception of those committed by the juvenile court to the city industrial school. There were no boys in this class under the moron grade, the number of feebleminded was only about one-third and the number of borderline cases only about one-half as large as in the whole clinic group, while there were about three times as many normals among the truants. On the other hand, the number of backward cases in the truant group was almost twice as great as in the general group. In other words, while fully 80 per cent of these delinquent boys were subnormal, not more than 11 per cent were of the feebleminded grade. While this is fully twenty times the ratio of mental defectives that obtains, according to our estimate, among all our elementary-school pupils, the conclusions we have reached from this study, and from other studies of the prevalence of mental defectives among delinquents, are more conservative than those of some writers. Moreover, for five years we have carefully scrutinized the elaborate reports we have annually received from the teachers on the scholarship and deportment of pupils assigned to our special classes. These reports have afforded no basis of fact whatever for the oft-repeated assertion that all mental defectives are either delinquents or potential delinquents. Suspecting that our teachers might have been overindulgent in making reports on conduct, we sent a questionnaire to each special school in May, 1918, asking the teachers to report "the names of pupils who have been a disciplinary problem during the year, including those hard to manage, truant, inclined to steal or lie, sexually immoral, or showing immoral tendencies. Indicate nature of offense and frequency and gravity."

The answers from the different schools to this question varied surprisingly. Three schools did not report a single child, and one reported only one—these schools apparently had no disciplinary problems to contend with—while one school reported over half of its attendance. This school is in one of the worst sections of the city, socially considered, with a preponderance of Italian and Jewish children, and the

teachers here took unusual pains to list all the undesirable traits exhibited by the pupils. Exclusive of this school, 10 boys were reported as truants, 12 boys and 1 girl were untruthful, 8 boys were mendacious, 9 boys and 2 girls were immoral. Each girl was involved with a different crowd of boys. Altogether, 5 of our girls had known immoral records this year, the girls being the aggressors in two cases, fortunately a situation that has not occurred before since the clinic was established. Two boys had violent tempers, 2 girls and 4 boys were hard to control, and 1 boy was pugnacious. Including the school with a preponderance of unstable types, 18 boys and 2 girls were truants, most of them, however, not habitually; 24 boys and 3 girls were given to stealing; 12 boys and 7 girls were immoral or showed immoral tendencies, while 4 boys practiced self-abuse; 20 boys and 3 girls showed a violent temper; 15 boys and 7 girls were hard to control; while 16 boys and 3 girls were pugnacious. The above figures cannot be summated, as some pupils are reported under two or three headings. But only a small percentage of the total number of pupils enrolled—323 boys and 148 girls—were reported.

The delinquency record of the pupils who withdrew from school was the worst this year, so far as reported to the writer, since the clinic was established, possibly owing to the general spirit of unrest. But even so, of the 88 withdrawals, only 6 boys and 4 girls had committed known offenses serious enough to require action on the part of the court or the school. Of the girls—all immoral—2 had been diagnosed as morons and 1 as border line, while the other had not been examined. Of the boys, 1 had been diagnosed as a middle-grade imbecile (ungovernable in school), 1 as a potential moron (stealing), 3 as morons (1 subject to a form of epilepsy, housebreaking, 1 stealing, and 1 troublesome to girls), and 1 as a border-line unstable (a truant who stayed out all night). All of these children were poorly supervised at home.

To put it briefly, we believe that misconduct among mental defectives is dependent upon native deficiency plus native instability plus unfavorable conditions in the environment. It is probably more dependent upon native instability than upon mental deficiency as such, assuming that reasonable

provision is made for the physical needs of the mental defective. Given the same parental care, supervision, and control that are given to normal children, a group of feebleminded children will not show a markedly higher ratio of delinquent conduct or criminality than a group of normal children. In other words, the greater prevalence of delinquency among the feebleminded is not due to positive viciousness, depravity, criminality, or even to instability, but to lack of care and protection. Under proper supervision, those feebleminded who commit crimes because of their defective powers of judgment and of inhibition, by reason of which they become the ready tools of evil designers, can be effectually restrained from committing serious offenses. Unfortunately many of the feebleminded do not receive this indispensable protection when at large in society, and this constitutes one of the chief arguments for the colonization of all feebleminded persons who are unprotected and dependent. But we are convinced that the number of delinquents who are of border-line or backward grade of intelligence is far greater than the number of feebleminded. The majority are subnormal, but certainly not feebleminded.

Since practically all scientists have been forced by the army results and the results of other intelligence surveys to abandon the concept of feeblemindedness when applied to the XII-year mentalities, the plea is put forth that we should recognize two types of feeblemindedness—namely, intellectual feeblemindedness, corresponding to the traditional limitation of the word, and feeblemindedness restricted to the field of feeling and volition, pathological affectivity, applicable to cases that show marked motor or emotional instability or lack of inhibition, although they may be only backward or may even be normal in intelligence. Under the latter conception, it would be possible to classify any delinquent as feebleminded if he can be shown to be defective in his emotional and volitional life. The writer is unable to accept this revised construction of the term. In the first place, there is at present no method available which is scientifically accurate by means of which we can measure the amount of emotional and volitional deficiency; hence, the diagnosis will be affected too largely by the examiner's subjective opinion. In the second place, we have

never yet been able to classify an emotionally and volitionally unstable individual as feebleminded unless he was also intellectually feebleminded. Such intellectually non-feebleminded emotional and volitional abnormals have been either neurotics, unstables (after Binet), choreics, epileptics, psychopathics, or psychotics, and, on the side of intelligence, border line, backward, normal, or supernormal. If they have been classed as feebleminded, it has been because of serious present intellectual deficiency, or because we had reason to believe that the intellectual deficiency would become very marked before the individual attained maturity. We believe that it is in the interest of scientific clearness to hold to this definite limited conception of feeblemindedness.

The largest percentage of feeblemindedness found in any of our groups—51.6 per cent—was found among the epileptics, the excess being most marked in the imbecile grade. On the other hand, the border-line and backward cases were less numerous among the epileptics, while the normals were more numerous. Curiously, only one of our public-school epileptics had a delinquent record at the time of the examination—a boy who was diagnosed as a border-line case. There are few institutional groups in which misconduct is more rife than among epileptics.

The proportion of mental defectives among our psychopathic cases was 8.5 per cent less than among all the examinees. None of the psychopaths graded lower than morons, while the majority of the mental defectives in the unstable and neurotic group were imbeciles. The proportion of border-line and backward cases was about the same in both of these groups as in the general group.

We made a special analysis of the delinquents diagnosed as psychopathic and unstable. Only eight delinquents were diagnosed as psychopaths—which is 2.3 per cent of the delinquents and 44 per cent of the psychopaths—while only twenty-one delinquents were diagnosed as unstable or neurotic, which is 6 per cent of the delinquents and 18.1 per cent of the neurotics. In other words, only a small percentage of the delinquents were psychopaths or unstables, while over 50 per cent of the psychopaths and over 80 per cent of the unstables were not delinquents. Binet has used the terms unstable or ill

balanced as practically equivalent to the terms unruly, delinquent, and undisciplined. Otherwise I know of no claim that there is a necessary or an invariable connection between instability or neuroticism and delinquency, although most criminologists would no doubt maintain that more neurotics than normals become offenders. Such a connection, however, does seem to be postulated between psychopathy and criminality. Birnbaum is one of the few who has denied this: "In characterizing, therefore, an individual as a psychopathic or degenerative personality, one is not to conclude that because of this he is also a social menace or even criminally inclined."* Paraphrasing Healy, we may say that classing a delinquent as a psychopath is not a sufficient explanation of his delinquency. Other factors must be considered both in the individual and in his environment. For example, many of our psychopaths and unstables may develop delinquent traits as they grow older, but this is of no special importance unless they develop a greater degree of delinquency, as a group, than the normal, backward, border-line, or feebleminded groups.

Heredity

Most of our data on heredity were gathered by the school physicians and nurses. Their scientific qualifications for doing this work were quite equal to those of the majority of field workers who have gathered the vast bulk of the hereditary data published in this country. We have tabulated these data for a two-year period, have reviewed them all as they have reached us, and frequently have supplemented them by independent inquiries. Candor, however, forces us to make the admission that this type of investigation represents the least satisfactory phase of our researches. It is almost impossible to ferret out all the facts even in the case of the living of the first generation, not to mention the dead of prior generations. Where valuable clues can be obtained, it has not been feasible to bring the suspects to competent diagnosticians for examination, so that the diagnoses have in almost all cases perforce been made from descriptions given by parents or acquaintances, from personal observations, and from interviews. All

* Birnbaum, Karl. Die Psychopathischen Verbrecher. Berlin: P. Langenscheidt, 1914. See also Mental Hygiene, Vol. III, pp. 157-166, January, 1919.

the data seem to us so conjectural that we have grave scruples about presenting them as scientific material.

From what we have said, it must not be inferred that we do not believe that heredity is a factor in the production of abnormal or normal intelligence. But we do hold that the methods of gathering heredity data which are in almost universal use, and which we have been obliged to follow, are so inadequate that the results obtained can scarcely be considered as matter of exact science. We cannot alter this situation by ignoring it or denying it.

We will, however, venture the statement that of the thousands of parents who have brought children to us for examination, certainly not more than twenty or thirty could have been committed to an institution as feebleminded. However, many parents have not come to the clinic. Had we seen all of them, the ratio might have been larger. It is significant, however, that our conclusion regarding the mental deficiency of parents who have come to our clinic is in complete agreement with Fernald's judgment regarding the parents of children in the Massachusetts Institution for the Feebleminded: "The average family chart of the patients admitted to the Massachusetts School for the Feebleminded is not a 'black' chart. . . . The average defective coming to the institution is not the child of a feebleminded parent or parents. Indeed, comparatively few of the parents observed would ever have been considered as candidates for segregation, even in the cases where the feeblemindedness was undoubtedly of hereditary origin."

TABLE VIII

Recommendations and Assignments of 1,965 Consecutive School Cases Examined from September, 1914, to June, 1919

	Total		Boys		Girls	
	No.	Per cent [1]	No.	Per cent [2]	No.	Per cent [3]
Recommended to Special Schools.	788	39.4	517	36.7	271	4.8
Retained in Special Schools.	44	2.2	24	1.7	20	3.5
(Special School Recommendations and Retentions).	832	41.6	541	38.4	291	51.5

TABLE VIII—(*Continued*).

	Total		Boys		Girls	
	No.	Per cent [1]	No.	Per cent [2]	No.	Per cent [2]
Recommended to or Assigned to "Combination Class"[4]	12	0.6	10	0.7	2	0.3
Recommended to Ungraded Classes[5]	775	38.8	606	43.0	169	30.0
Retained in Ungraded Classes	7	0.4	2	0.1	5	0.9
(Ungraded Class Recommendations and Retentions)	782	39.2	608	43.1	174	30.9
Assigned, Demoted to, or Retained in Kindergarten	60	3.0	32	2.3	28	5.0
Returned to Regular Grade	46	2.7	35	2.5	11	1.9
Retained in Grade School because of Low Mentality and Distance	2	0.1	2	0.1	0	0.0
Returned to or Recommended for the Boys' Classes	62	3.1	62	4.4	0	0.0
Recommended to or Retained in Open-air School	8	0.4	6	0.4	2	0.3
Assigned to or Returned to Industrial School	42	2.1	35	2.5	7	1.2
Assigned to Class for Foreigners	1	0.05	0	0.0	1	0.2
Recommended to Gallaudet[6]	25	1.3	18	1.3	7	1.2
Could not be Admitted because of Immoral Tendencies	1	0.05	0	0.0	1	0.2
Could not be admitted because of Low Mentality	59	3.0	37	2.6	22	3.7
Could not be admitted because of Under-Age or Over-age	2	0.1	1	0.07	1	0.2
Excluded because of Low Mentality	20	1.0	12	0.8	8[7]	1.4
Temporarily Excluded because of Chorea	1	0.05	0	0.0	1	0.2
(Non-admissions and Exclusions)	83	4.2	50	3.4	33	5.7

TABLE VIII—(*Concluded*).

	Total		Boys		Girls	
	No.	Per cent [1]	No.	Per cent [2]	No.	Per cent [3]
Retained at Home because of Removal.....	1	0.05	1	0.07	0	0.0
Recommended to an Institution because of Predementia-praecox Reactions.	2	0.1	0	0.0	2	0.3
Recommended to an Institution for the Feebleminded[8].	4	0.2	1	0.07	3	0.5
Recommended to Home for Delinquent Girls[9].	3	0.2	0	0.0	3	0.5

1. Based on the total number of boys and girls (1,965).
2. Based on the total number of boys (1,401).
3. Based on the total number of girls (564).
4. This has been a combination of an ungraded class and special school.
5. Many of these children should more properly have been assigned to a speech-correction class, or a school for neurotic children, or an elementary industrial or trade school, had the facilities been available.
6. Includes 5 boys and 2 girls who are deaf and 13 boys and 5 girls who are speech defectives. Gallaudet is the public day school for deaf and speech defective children.
7. Includes one with violent temper whose mentality was undetermined.
8. A very much larger number of pupils were recommended for commitment to the state institution for the feebleminded, but have been classified as being excluded or admitted to a special school because of the fact that the inadequate accommodations at the state institution made it impossible to admit them. Some children, however, after having been in special schools were admitted to the state institution.
9. Others have been sent to homes after spending some time in the special schools. In the case of reexamination the last recommendation is used.

COMPARATIVE STATISTICS OF STATE HOSPITALS FOR MENTAL DISEASES, 1918

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THE state hospitals for mental diseases in the United States, although organized under diverse laws, form a fairly homogeneous group. They are working under the same general plan; they have the same tasks, the same problems, and the same aims. Comparative statistics of these institutions and of their work should, therefore, be of special interest to superintendents, managers, and supervisory boards and should furnish to the people generally, usable information concerning the problem of the care of the mentally afflicted.

The data submitted in this review were compiled from reports made on standard schedules by the superintendents of the hospitals to the Bureau of Statistics of the National Committee for Mental Hygiene. Some of the data were taken from the annual reports of the institutions. It is to be regretted that, in spite of repeated efforts, no reports could be obtained from a few hospitals. In view of the difficult conditions prevailing in some of the hospitals during the year 1918, the coöperation of the superintendents who supplied the desired information was highly commendable. Although the study is not complete, this detracts little from its value, as it is made for purposes of comparison rather than as an enumeration to secure totals.

In considering the statistics here presented, it must be remembered that the fiscal year which ended in 1918 was a year of warfare. The medical staffs and the forces of employees of the institutions were depleted as never before. Good food was scarce and expensive, and many other needed supplies could not be obtained. The energy of the whole nation was given to the one task of winning the war. The

conditions indicated by the figures, therefore, are not typical, but the data furnish a basis for a comparison of hospital conditions in war times with those in more normal years.

The statistical data submitted relative to the state hospitals are classified under the following ten headings, each of which is the subject of a separate table:

1 Patients, physicians, and employees
2 Value and acreage of hospital plants
3 Expenditures for maintenance of patients and for additions and improvements
4 Comparison of cost of maintenance of patients
5 Movement of patient population
6 Sex distribution of admissions
7 Patients discharged as recovered and improved
8 Death rates
9 Admissions in 1910 and 1918 compared
10 Deaths in 1910 and 1918 compared

Analysis of Statistical Tables

Table 1. Patients, physicians, and employees of state hospitals for mental diseases in the United States at the end of the fiscal year 1918.

This table gives a complete list of the state hospitals in the several states of the United States, and, so far as reported, the date of opening, the number of resident patients, physicians, graduate nurses, other nurses and attendants, and other employees in each hospital at the end of the fiscal year; also the number of patients to each physician, each employee, and each ward employee. St. Elizabeths Hospital, the government institution at Washington, D. C., and the federal Asylum for Insane Indians, in South Dakota, are included in the table.

Previous to the war it was deemed necessary to have 1 physician to each 150 or 175 patients, 1 employee to each 5 or 6 patients, and 1 ward employee to each 8 or 9 patients. Only a few of the state hospitals were able to maintain this prewar standard of care during 1918. The small number of graduate nurses employed in some of the hospitals was especially deplorable. The average of the 139 ratios of patients to

physicians given in the table is 257.3 to 1; the average of the 134 ratios of patients to employees is 7.5 to 1; and the average of the 132 ratios of patients to ward employees is 13.6 to 1. The general average ratios were 242.7 to 1, 6.9 to 1, and 12.5 to 1, respectively. A wide range of variation from the average ratios is seen in the figures of the separate institutions.

Table 2. Value and acreage of plants of state hospitals for mental diseases as reported by the superintendents.

In reporting the value of hospital property the superintendents were requested to appraise the property at cost unless the original plant had suffered depreciation. In case the cost could not be ascertained or if the plant had depreciated, the estimate was to represent as nearly as possible the true value of the property. As many of the institutions have existed for several years, and as the cost of building has greatly increased since their erection, it becomes difficult to make an accurate estimate of the value that should be placed upon such institutions at the present time. The figures given in the table were submitted directly by the superintendents or were taken from reports prepared by them. It is clear that figures obtained in this way must be considered as estimates, and due allowance must be made for differences in personal judgments. It is probable, however, that the amounts stated in nearly every case are less than the renewal value of the property. The total value of all the property of hospitals from which reports were received, as outlined in this table, is $197,261,782. The extraordinarily wide variations in estimated value of personal property in institutions of practically the same size are probably due in part to the lack of uniformity of view as to what constitutes personal property. The value of property per patient varies widely. The average per capita of the 127 items given in the table is $1,192.52 and the general average per capita, $1,060.03.

The investments in hospital property made by the more populous states for the care of mental cases are enormous. The total of such investments as reported in 1918 in New York was $40,430,220; in Ohio, $14,486,093; in Pennsylvania, $12,499,561; in Massachusetts (exclusive of Bridgewater), $18,904,544.

The figures giving acreage of the hospital plants are impressive. They show that nearly all of the institutions are generously equipped with farms and grounds which afford opportunity for expansion far beyond present limits. The total number of acres reported was 97,085, of which 48,398 were under cultivation. The average acreage of the plants of the 134 hospitals reporting is 727. The average of the 130 ratios of acres to patients is 0.70 to 1, the general average ratio being 0.51 to 1.

Table 3. Expenditures for maintenance of patients and for additions and improvements in the state hospitals for mental diseases for the fiscal year 1918.

This table shows the date at which the fiscal year ends in each institution, the average daily patient population, the total and per capita expenditures for maintenance, and the expenditures for additions and improvements. In collecting and compiling these figures, care was taken to separate capital charges from expenses, and it is believed that the amounts given for maintenance represent only the cost of the care of patients and the upkeep of the hospital plant. The per capita cost in the several hospitals varies considerably, due in part to differences in cost of labor and supplies and in part to differences in standards of care. The size of the institution also has an important bearing on the per capita cost. Other things being equal, a large institution will have a lower per capita cost than a small one. Many factors, however, must be taken into consideration. The average of the per capita costs of the 142 institutions reporting was $254.09. The general average per capita cost for all patients was $244.21. On account of the high cost of building, the scarcity of materials, and the restrictions on building necessitated by the war, the expenditures for additions and improvements to state hospitals were comparatively small in 1918, the total amount reported being $5,070,856.60.

Table 4. Comparison of cost of maintenance of patients in state hospitals for mental diseases for 1917 and 1918.

This table gives a view of the effect of the first year of the war in raising the cost of maintenance of patients in the several states. In all but five of the states, a marked increase

in the per capita cost of maintenance in 1918 over that of 1917 is shown. In Wyoming the increase was $70.73 per capita; in Massachusetts, $63.22; in New York, $43.54; in Connecticut, $48.20; in Oregon, $48.67; in Texas, $39.79; and in Montana, $44.33. Had pre-war standards been maintained, the per capita increase would have been much greater. In 1917 the per capita cost of maintenance in all state hospitals was $207.28.* In 1918 the average per capita cost of the hospitals of those states from which complete reports were received was $241.83.

Table 5. Movement of patients in the state hospitals for mental diseases for the fiscal year 1918.

This table was prepared from a standard form adopted by the American Medico-Psychological Association. The data with respect to the classification of admissions as first admissions or readmissions are incomplete, as the distinction called for had not been made by several of the hospitals. The term "first admissions" includes all insane patients admitted for the first time to any institution for the insane, excepting institutions for temporary care only. "Readmissions" includes all insane patients admitted who have been previously under treatment in an institution for the insane, excepting transfers and patients who have received treatment only in institutions for temporary care. The classification of discharged cases also was rendered difficult by the fact that the data in some of the hospitals had not been kept in accordance with the plan for uniform statistics. The table, with these exceptions, gives a condensed view of the movement of patients in the several hospitals for the fiscal year. It is unfortunate that totals for all the state hospitals of the country cannot be given.

Table 6. Sex distribution of admissions to state hospitals for mental diseases during the fiscal year 1918.

This table gives the sex distribution of admissions by states and shows first admissions, readmissions, and transfers in the states where the admissions were thus classified. As the yearly number of first admissions indicates better than any

* See Annual Census of the Insane, Feebleminded, Epileptics, and Inebriates in Institutions in the United States, January 1, 1918. By Horatio M. Pollock and Edith M. Furbush. MENTAL HYGIENE, Vol. III, No. 1, pp. 78-107. January, 1919.

other available data the rate of incidence of mental disease, it is highly important that these cases be distinguished from readmissions and transfers. Reference to the table shows a marked predominance of males over females among first admissions in every section of the country. Of the first admissions reported, 16,368 were males and 13,200 females. The cause of the excess of males is found principally in the greater prevalence of general paralysis in this sex.

Table 7. Patients discharged as recovered and improved from the state hospitals for mental diseases in the United States during the fiscal year 1918.

This table gives the sex of patients reported as recovered and improved, and the rate of cases discharged as recovered and improved per 100 admissions, exclusive of transfers. As the number of admissions to the several hospitals is not uniform year by year, the total admissions do not form a satisfactory basis for the computation of rates of recovery, but it is quite generally used for this purpose, as the total under treatment or average daily population are even less satisfactory. Very wide differences in rates of recovery and improvement are shown in the several hospitals. These are due in part to differences in the use of terms and in part to differences in results obtained from the treatment of patients.

In order to standardize the use of the terms "recovered" and "improved," they are defined in the *Statistical Manual** as follows:

"Recovered" indicates the condition of patients who have regained their normal mental health so that they may be considered as having practically the same mental status as they had previous to the onset of the psychosis.

"Improved" denotes any degree of mental gain less than recovery.

Table 8. Deaths of patients in the state hospitals for mental diseases for the fiscal year 1918.

The deaths are shown by sexes, and the rates for each sex are shown per 1,000 of daily average population and per 1,000 of patients under treatment. The latter base is the

* Statistical Manual for the Use of Institutions for the Insane. Published by the Bureau of Statistics of the National Committee for Mental Hygiene. New York, 1918. 40 p.

one more generally used. The death rate in the hospitals is influenced by the sex and age distribution and by the mental and physical condition of the patients, as well as by the standard of care and maintenance. As a rule, death rates among male patients are higher than among female. This is partly accounted for by the large number of deaths among male paretic patients.

Table 9. Admissions of patients with mental diseases to the state hospitals in 1910 and in 1918.

This table compares admissions to state hospitals in the several states in 1910 and 1918, where complete data were obtained, and gives the rate of admission per 100,000 of general population. A marked increase in the rate of admission is shown in the majority of states. The states in which the increase is most striking are shown by the following table:

State	Number of admissions per 100,000 of general population	
	1910	1918
Arkansas	16.2	67.2
Florida	43.2	74.7
Illinois	46.9	98.6
Massachusetts	117.1	149.4
Michigan	54.2	79.7
Montana	73.9	123.0
New Hampshire	69.7	100.1

The following table shows those states in which there was a decrease in the rate of admission to state hospitals from 1910 to 1918:

State	Number of admissions to state hospitals per 100,000 of general population	
	1910	1918
Colorado	44.2	40.8
Delaware	62.8	59.7
Kansas	36.6	35.8
Nevada	68.4	58.5
North Carolina	37.3	30.6
South Dakota	34.1	32.8
Texas	32.5	30.7
Washington	77.4	67.5
Wisconsin	48.0	47.1

The causes for the changes in rates in these states are not known.

Table 10. Deaths of patients with mental diseases in the state hospitals in 1910 and 1918.

This table compares results in state hospitals with respect to the deaths of patients in 1910 and 1918 in states where complete data were obtained. In most of the states a marked increase in death rates is shown. This is due in part to the accumulation of old cases in the hospitals and probably in part to the lack of adequate medical and nursing care during this exceptional year.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Alabama†:										
The Bryce Hospital	1861	2,230	7	318.6	10	140	104	254	8.8	14.9
The Mt. Vernon Hospital	1901									
Arizona:										
Arizona State Hospital	‡	520	‡	‡	‡	‡	‡	‡	‡	‡
Arkansas:										
State Hospital for Nervous Diseases	1882	1,971	7	281.6	3	124	88	215	9.2	15.5
California:										
Agnews State Hospital	1888	1,619	6	269.8	5	116	61	182	8.9	13.4
Mendocino State Hospital	1893	1,141	4	285.3	.....	68	78	146	7.8	16.8
Napa State Hospital	1875	2,375	12	197.9	.....	181	115	296	8.0	13.1
Norwalk State Hospital	1915	233	‡	‡	‡	‡	‡	‡	‡	‡
Southern California State Hospital	1893	2,172	9	241.3	3	211	76	290	7.5	10.1
Stockton State Hospital	1851	2,488	7	355.4	2	171	113	286	8.7	14.4
Colorado:										
Colorado State Hospital	1879	1,692	5	338.5	.....	109	56	165	10.3	15.5
Connecticut:										
Connecticut State Hospital	1868	2,592	9	288.0	25	168	187	380	6.8	13.4
Norwich State Hospital for the Insane*	1904	1,338	7	191.1	17	116	66	199	6.7	10.1
Delaware:										
Delaware State Hospital at Farnhurst	1889	500	2	250.0	.....	70	29	99	5.1	7.1

* 1919 data. † Hospitals under one management. ‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
District of Columbia:										
St. Elizabeths Hospital	1885	3,375	17	198.5	68	112	388	568	5.9	18.8
Florida:										
Florida Hospital for the Insane	1876	1,403	5	280.6	3	201	85	289	4.9	6.9
Georgia:										
Georgia State Sanitarium	1844	3,785	10	378.5	‡	‡	‡	‡	‡	‡
Idaho:										
The Idaho Insane Asylum‡										
Northern Idaho Sanitarium‡										
Illinois:										
Alton State Hospital	1914	701	3	233.7	3	60	46	109	6.4	11.1
Anna State Hospital	1874	1,754	7	250.6	12	179	96	287	6.1	9.2
Chester State Hospital‡										
Chicago State Hospital	1912	3,241	‡	‡		266	103	369	8.8	12.2
Elgin State Hospital	1870	2,100	8	262.5	22	183	89	294	7.1	10.2
Jacksonville State Hospital	1846	2,585	11	235.0	12	165	113	290	8.9	14.6
Kankakee State Hospital	1879	3,226	11	293.3	29	264	163	456	7.1	11.0
Peoria State Hospital	1902	2,242	12	186.8	23	199	102	324	6.9	10.1
Watertown State Hospital	1898	1,604	8	200.5	9	180	91	280	5.7	8.5

‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Indiana:										
Central Indiana Hospital for the Insane	1848	1,412	7	201.7	.....	120	154	274	5.2	11.8
Eastern Indiana Hospital for the Insane	1890	874	6	145.7	2	70	48	120	7.3	12.1
Indiana Hospital for Insane Criminals.	1912	180	1	180.0	.....	13	.....	13	13.8	13.8
Northern Hospital for the Insane.....	1888	934	4	233.5	.....	68	70	138	6.8	13.7
Southeastern Hospital for the Insane..	1910	1,176	5	235.2	.....	102	59	161	7.3	11.5
Southern Indiana Hospital for the Insane‡.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Iowa:										
Cherokee State Hospital.....	1902	1,121	5	224.3	‡	‡	‡	‡	‡	‡
Clarinda State Hospital.....	1888	1,198	5	239.6	14	76	59	149	8.0	13.3
Independence State Hospital.....	1873	1,125	6	187.5	25	59	65	149	7.6	13.4
Mount Pleasant State Hospital.....	1861	1,108	4	277.0	8	62	81	151	7.3	15.8
The Reformatory‡.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Kansas:										
Hospital for the Dangerous Insane....	1911	65	1	65.0	2	.....	2	4	16.3	32.5
Larned State Hospital.....	1913	111	1	111.0	‡	‡	‡	‡	‡	‡
Osawatomie State Hospital.....	1865	1,347	4	336.8	7	78	96	181	7.4	15.8
Topeka State Hospital.....	1875	1,545	6	257.5	28	70	71	169	9.1	15.8
Kentucky:										
Central State Hospital.....	1875	1,640	3	546.7	12	73	90	175	9.4	19.3
Eastern State Hospital.....	1818	1,347	4	336.8	8	77	57	142	9.5	15.8
Western State Hospital‡.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Louisiana:										
East Louisiana Hospital for the Insane.	1847	1,665	4	416.3	.....	79	92	171	9.7	21.1
Louisiana Hospital for the Insane.....	1906	920	4	230.0	.....	44	37	81	11.4	20.9
Maine:										
Augusta State Hospital.....	1840	1,059	6	176.5	18	104	106	228	4.6	8.7
Bangor State Hospital.....	1901	701	4	175.3	6	66	90	162	4.3	9.7
Maryland:										
Crownsville State Hospital‡.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Eastern Shore State Hospital.....	1915	236	2	118.0	2	22	16	40	5.9	9.8
Spring Grove State Hospital.....	1872*	794	3	264.7	.....	50	48	98	8.1	15.9
Springfield State Hospital†.....	1896	1,474	6	245.7	22	87	62	171	8.6	13.5
Massachusetts:										
Boston State Hospital.....	1839	1,640	24	68.3	19	186	193	398	4.1	8.0
Bridgewater State Hospital.....	1886	807	3	269.0	1	61	2	64	12.6	13.0
Danvers State Hospital.....	1878	1,502	5	300.4	14	105	151	270	5.6	12.6
Foxborough State Hospital.....	1914	456	4	114.0	.....	52	84	136	3.4	8.8
Gardner State Colony.....	1902	790	6	131.7	1	79	94	174	4.5	9.9
Grafton State Hospital.....	1877	1,824	7	260.6	20	123	170	313	5.8	12.8
Medfield State Hospital.....	1896	1,533	6	255.5	5	121	166	292	5.3	12.2
Northampton State Hospital.....	1858	1,013	8	126.6	3	213	165	381	2.7	4.7
State Infirmary.....	1856	711	6	118.5	19	104	161	284	2.5	5.8
Taunton State Hospital.....	1854	1,306	9	145.1	21	44	118	183	7.1	20.1
Westborough State Hospital.....	1886	1,239	5	247.8	21	85	132	238	5.2	11.7
Worcester State Hospital.....	1833	1,578	6	263.0	14	101	140	255	6.2	13.7

* Original hospital opened at Baltimore City in 1797. † 1919 data. ‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Michigan:										
Ionia State Hospital	1885	491	3	163.7	.....	38	29	67	7.3	12.9
Kalamazoo State Hospital	1849	2,207	9	245.2	12	174	188	374	5.9	11.9
Newberry State Hospital	1895	1,020	3	340.0	19	47	75	141	7.2	15.5
Pontiac State Hospital	1878	1,475	6	245.8	60	74	102	236	6.3	11.0
State Psychopathic Hospital	1906	61	6	10.2	3	16	16	35	1.7	3.2
Traverse City State Hospital	1885	1,855	5	371.0	26	142	112	280	6.6	11.0
Minnesota:										
Anoka State Asylum	1900	849	1	849.0	10	46	17	73	11.6	15.2
Fergus Falls State Hospital	1890	1,605	5	321.0	30	92	92	214	7.5	13.2
Hastings State Asylum	1900	961	1	961.0	2	56	26	84	11.4	16.6
Rochester State Hospital	1879	1,394	5	278.8	21	95	92	208	6.7	12.0
St. Peter State Hospital†	1866	1,384	7	197.7	19	93	82	194	7.1	12.4
Willmar State Asylum	1917	90	1	90.0	.....	9	19	28	3.2	10.0
Mississippi:										
East Mississippi Insane Hospital‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Mississippi State Insane Hospital†	1855	1,574	5	314.8	1	68	92	161	9.8	22.8
Missouri:										
State Hospital No. 1	1847	1,256	4	314.0	.....	76	60	136	9.2	16.5
State Hospital No. 2	1874	1,723	5	344.6	.....	116	85	201	8.6	14.9
State Hospital No. 3	1887	1,204	4	301.0	2	83	66	151	8.0	14.2
State Hospital No. 4	1903	764	3	251.3	.....	57	35	92	8.3	13.4
Montana:										
Montana State Hospital for the Insane‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

† 1919 data.

‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Nebraska:										
Hospital for the Insane of Nebraska (Norfolk)	1887	623	4	155.8	6	50	31	87	7.2	11.1
Ingleside Hospital for the Insane	1888	1,162	6	193.7	.....	99	55	154	7.5	11.7
Nebraska Hospital for the Insane (Lincoln)	1870	786	4	196.5	3	61	42	106	7.4	12.3
Nevada:										
Nevada Hospital for Mental Diseases‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
New Hampshire:										
New Hampshire State Hospital	1842	1,281	6	213.5	6	101	132	239	5.4	12.0
New Jersey:										
The New Jersey State Hospital at Morris Plains†	1876	2,665	8	333.1	31	161	288	480	5.6	13.9
The New Jersey State Hospital at Trenton†	1848	1,898	‡	‡	4	138	163	305	6.2	13.4
New Mexico:										
State Hospital	1893	321	1	321.0	1	39	15	55	5.8	8.0
New York:										
Binghamton State Hospital	1881	2,701	8	337.6	39	217	172	428	6.3	10.6
Brooklyn State Hospital	1895	884	7	126.3	16	58	83	157	5.6	11.9
Buffalo State Hospital	1880	2,202	8	275.3	113	118	183	414	5.3	9.5
Central Islip State Hospital	1896	5,040	21	240.0	105	290	284	679	7.4	12.8
Dannemora State Hospital	1900	543	3	181.0	.....	66	37	103	5.3	8.2
Gowanda State Homeopathic Hospital	1898	1,281	5	256.2	23	57	81	161	8.0	16.0

† 1919 data.

‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
New York—Concluded:										
Hudson River State Hospital	1871	3,428	11	311.6	73	274	246	593	5.8	9.9
Kings Park State Hospital	1896	4,479	19	235.7	82	287	342	711	6.3	12.1
Manhattan State Hospital	1896	5,327	25	213.1	78	381	283	742	7.2	11.6
Matteawan State Hospital	1859*	877	4	219.3	5	118	60	183	4.8	7.1
Middletown State Homeopathic Hospital	1874	2,181	7	311.6	54	147	156	357	6.1	10.9
Rochester State Hospital	1891	1,541	8	192.6	81	86	122	289	5.3	9.2
St. Lawrence State Hospital	1890	2,285	9	253.9	30	235	158	423	5.4	8.6
Utica State Hospital	1843	1,687	7	241.0	11	133	150	294	5.7	11.7
Willard State Hospital	1869	2,426	10	242.6	66	128	233	427	5.7	12.5
North Carolina:										
State Hospital at Goldsboro	1880	962	4	240.5	.....	39	33	72	13.4	24.7
State Hospital (Morganton)‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
State Hospital (Raleigh)	1854	1,065	4	266.3	5	74	78	157	6.8	13.5
State Hospital for Dangerous Insane‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
North Dakota:										
State Hospital for the Insane‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Ohio:										
Athens State Hospital	1874	1,339	5	267.8	16	71	77	164	8.2	15.4
Cleveland State Hospital	1885	1,831	6	305.2	24	101	67	192	9.5	14.6
Columbus State Hospital	1838	1,869	‡	‡	‡	‡	‡	‡	‡	‡
Dayton State Hospital	1855	1,284	5	256.8	23	32	127	182	7.1	23.3

* Date of opening at Auburn; at Matteawan, 1892.

‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Ohio—Concluded:										
Lima State Hospital for the Criminal Insane	1915	821	4	205.2	11	84	58	153	5.4	8.6
Longview Hospital	1821	1,515	4	378.8	.....	97	54	151	10.0	15.6
Massillon State Hospital	1898	1,906	6	317.7	.....	81	53	134	14.2	23.5
Toledo State Hospital	1888	1,871	5	374.2	.....	113	105	218	8.6	16.6
Oklahoma:										
East Oklahoma Hospital	.....	897	‡	‡	‡	‡	‡	‡	‡	‡
Central Oklahoma State Hospital	1895	914	4	228.5	3	65	34	102	9.0	13.4
Western Oklahoma Hospital	1908	483	2	241.5	.....	22	27	49	9.9	22.0
Oregon:										
Eastern Oregon State Hospital	1913	515	3	171.7	‡	‡	‡	52	9.9	‡
Oregon State Hospital	1883	1,631	7	233.0	1	117	73	191	8.5	13.8
Pennsylvania:										
Homeopathic State Hospital (Allentown)	1912	1,112	6	185.3	10	80	90	180	6.2	12.4
Pennsylvania State Lunatic Hospital (Harrisburg)	1851	1,383	5	276.6	.....	93	94	187	7.4	14.9
The State Asylum for the Chronic Insane of Pennsylvania (Wernersville)	1894	921	3	307.0	.....	66	73	139	6.6	14.0
State Hospital (Warren)	1880	1,499	9	166.6	28	93	153	274	5.5	12.4
State Hospital for the Criminal Insane	1912	440	3	146.7	.....	45	57	102	4.3	9.8

‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Continued

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Pennsylvania—Concluded:										
State Hospital for the Insane (Danville)	1872	1,678	7	239.7	70	66	123	259	6.5	12.3
State Hospital for the Insane (Norristown)	1880	2,962	9	329.1	75	205	229	509	5.8	10.6
Rhode Island:										
State Hospital for Mental Diseases	1870	1,390	7	198.6	12	138	51	201	6.9	9.3
South Carolina:										
State Hospital for the Insane	1827	2,148	9	238.7	17	129	130	276	7.8	14.7
South Dakota:										
Asylum for Insane Indians	1902	81	1	81.0	.....	6	13	19	4.3	13.5
Yankton State Hospital	1879	1,077	5	215.4	2	64	83	149	7.2	16.3
Tennessee:										
Central State Hospital	1852	781	5	156.2	1	61	47	109	7.2	12.6
Eastern State Hospital	1886	649	4	162.3	.....	55	51	106	6.1	11.8
Western State Hospital	.....	779	3	259.7	‡	‡	‡	‡	‡	‡
Texas:										
North Texas Hospital for the Insane	1885	1,910	6	318.3	‡	‡	‡	‡	‡	‡
Southwestern Insane Asylum	1891	1,985	7	283.6	2	142	94	238	8.3	13.8
State Lunatic Asylum	1857	1,806	5	361.2	.....	62	148	210	8.6	29.1
Utah:										
State Mental Hospital	1885	648	1	648.0	.....	42	26	68	9.5	15.4

‡ Data not available.

Table I—Patients, physicians and employees of the state hospitals for mental diseases in the United States at the end of the fiscal year 1918—Concluded

HOSPITAL	Date of opening	Patients, excluding paroles	Number of physicians	Number of patients to each physician	Employees				Number of patients to each employee	Number of patients to each nurse and attendant
					Graduate nurses	Other nurses and attendants	Others	Total		
Vermont:										
Vermont State Hospital for the Insane	1891	732	5	146.4	12	62	54	128	5.7	9.9
Virginia:										
Central State Hospital	1869	1,810	3	603.3	5	69	41	115	15.7	24.5
Eastern State Hospital	1773	795	3	265.0	.....	44	44	88	9.0	18.1
Southwestern State Hospital	1887	698	3	232.7	2	55	46	103	6.8	12.2
Western State Hospital	1828	1,184	4	296.0	4	70	87	161	7.4	16.0
Washington:										
Eastern State Hospital	1891	1,180	3	393.3	.....	71	31	102	11.6	16.6
Northern State Hospital	1911	840	3	280.0	.....	59	32	91	9.2	14.2
Western State Hospital	1871	1,419	4	354.8	.....	89	41	130	10.9	15.9
West Virginia:										
Huntington State Hospital	1897	758	3	252.7	.....	22	31	53	14.3	34.5
Spencer State Hospital	1893	597	2	298.5	.....	39	29	68	8.8	15.3
Weston State Hospital	1859	1,107	4	276.8	.....	84	46	130	8.5	13.2
Wisconsin:										
Central State Hospital for the Insane	1914	102	1	102.0	1	11	10	22	4.6	8.5
Northern Hospital for the Insane	1873	624	5	124.8	‡	‡	‡	‡	‡	‡
Wisconsin State Hospital for the Insane	1860	652	5	130.4	‡	‡	‡	‡	‡	‡
Wyoming:										
Wyoming State Hospital for the Insane	1889	251	1	251.0	.....	15	7	22	11.4	16.7
Total reported	.....	203,750	804	242.7	1,894	13,336	12,379	27,661§	6.9	12.5

‡ Data not available.

§ Includes 52 undistributed.

Table II—Value and acreage of plants of state hospitals for mental diseases as reported by superintendents

HOSPITAL	Value of Property				Acreage		
	Real estate	Personal property	Total	Per patient*	Under cultivation	Total	Per patient*
Alabama:							
The Bryce Hospital	$200,000	$100,000	$300,000	†	400	1,500	†
The Mt. Vernon Hospital	100,000	50,000	150,000	†	400	1,800	†
Arizona:							
Arizona State Hospital†							
Arkansas:							
State Hospital for Nervous Diseases	1,208,509	226,019	1,434,528	$713 .34	50	160	0.03
California:							
Agnews State Hospital	1,498,807	207,212	1,706,019	1,041.53	150	319	0.19
Mendocino State Hospital	620,570	178,642	799,212	691.96	417	905	0.78
Napa State Hospital	†	†	3,843,592	1,653.87	704	1,899	0.81
Norwalk State Hospital†							
Southern California State Hospital	1,379,261	253,520	1,632,781	685.47	236	386	0.16
Stockton State Hospital	2,320,182	237,194	2,557,376	1,045.96	1,050	1,354	0.55
Colorado:							
Colorado State Hospital	1,135,000	268,317	1,403,317	852.56	40	112	0.07
Connecticut:							
Connecticut State Hospital	3,184,396	527,825	3,712,221	1,419.04	394	776	0.30
Norwich State Hospital for the Insane‡	1,176,096	97,347	1,273,443	1,034.48	147	539	0.44
Delaware:							
Delaware State Hospital at Farnhurst	600,000	50,000	650,000	1,272.02	40	90	0.18
District of Columbia:							
St. Elizabeths Hospital	3,932,832	1,027,193	5,060,025	1,519.53	447	803	0.24
Florida:							
Florida Hospital for the Insane	750,000	250,000	1,000,000	644.75	400	1,900	1.23
Georgia:							
Georgia State Sanitarium†							
Idaho:							
The Idaho Insane Asylum†							
Northern Idaho Sanitarium†							
Illinois:							
Alton State Hospital	1,144,305	22,254	1,166,559	2,744.84	400	1,035	2.44
Anna State Hospital	1,236,906	246,555	1,483,461	831.07	315	563	0.32
Chester State Hospital†							
Chicago State Hospital	†	†	2,500,000	746.49	110	240	0.07
Elgin State Hospital	1,335,632	282,803	1,618,435	787.18	310	517	0.25
Jacksonville State Hospital	1,256,055	234,995	1,491,050	710.70	200	360	0.17
Kankakee State Hospital	1,820,875	429,130	2,250,005	684.10	†	840	0.26

* Based upon average daily number of patients in hospital during the last year.
† Data not available. ‡ 1919 data.

Table II—Value and acreage of plants of state hospitals for mental diseases as reported by superintendents—Continued

HOSPITAL	Value of Property				Acreage		
	Real estate	Personal property	Total	Per patient*	Under cultivation	Total	Per patient*
Illinois—Concluded:							
Peoria State Hospital	$1,457,687	$587,090	$2,044,777	$879.47	300	600	0.26
Watertown State Hospital	1,091,803	218,364	1,310,167	777.55	300	593	0.35
Indiana:							
Central Indiana Hospital for the Insane	1,677,192	433,578	2,110,770	1,405.31	55	160	0.11
Eastern Indiana Hospital for the Insane	966,406	207,142	1,173,548	1,347.36	593	869	1.00
Indiana Hospital for Insane Criminals	75,000	10,000	85,000	477.53	1	4	0.02
Northern Hospital for the Insane	790,910	160,359	951,269	991.94	120	271	0.28
Southeastern Hospital for the Insane	1,561,938	181,066	1,743,004	1,494.86	500	1,158	0.99
Southern Indiana Hospital for the Insane†	.....	.....	.....	.....	.....	.....	.....
Iowa:							
Cherokee State Hospital†	.....	.....	.....	.....	.....	.....	.....
Clarinda State Hospital	1,263,631	192,083	1,455,714	1,218.17	725	860	0.72
Independence State Hospital	1,073,698	175,000	1,248,698	1,087.72	700	1,360	1.18
Mount Pleasant State Hospital	1,142,415	228,365	1,370,780	1,223.91	537	1,036	0.93
The Reformatory†	.....	.....	.....	.....	.....	.....	.....
Kansas:							
Hospital for the Dangerous Insane†	.....	.....	.....	.....	.....	.....	.....
Larned State Hospital	177,180	†	†	†	†	†	†
Osawatomie State Hospital	1,000,000	150,000	1,150,000	855.02	300	727	0.54
Topeka State Hospital	1,383,500	200,000	1,583,500	1,018.33	175	450	0.29
Kentucky:							
Central State Hospital	1,250,000	250,000	1,500,000	.....	450	600	.....
Eastern State Hospital	651,815	440,849	1,091,664	811.04	150	225	0.17
Western State Hospital†	.....	.....	.....	.....	.....	.....	.....
Louisiana:							
East Louisiana Hospital for the Insane	†	†	†	†	750	1,906	1.14
Louisiana Hospital for the Insane	349,227	39,021	388,248	431.39	1,000	1,700	1.89
Maine:							
Augusta State Hospital	1,894,740	202,124	2,096,864	2,027.91	450	600	0.58
Bangor State Hospital	956,882	127,227	1,084,109	1,546.52	200	250	0.36
Maryland:							
Crownsville State Hospital†	.....	.....	.....	.....	.....	.....	.....
Eastern Shore State Hospital	231,384	72,530	303,914	1,266.31	120	250	1.04

* Based upon average daily number of patients in hospital during the last year.
† Data not available.

Table II—Value and acreage of plants of state hospitals for mental diseases as reported by superintendents—Continued

HOSPITAL	Value of Property				Acreage		
	Real estate	Personal property	Total	Per patient*	Under cultivation	Total	Per patient*
Maryland—Concluded:							
Spring Grove State Hospital	$892,606	$126,696	$1,019,302	$1,287.00	500	600	0.76
Springfield State Hospital‡	1,436,716	166,621	1,603,337	†	513	960	†
Massachusetts:							
Boston State Hospital	2,996,904	310,196	3,307,100	2,070.82	60	235	0.15
Bridgewater State Hospital†	.....	.....	.....	.....	.....	.....	.....
Danvers State Hospital	2,346,990	284,136	2,631,126	1,751.75	300	517	0.34
Foxborough State Hospital	523,099	102,379	625,478	1,616.22	65	263	0.68
Gardner State Colony	551,909	134,403	686,312	862.20	290	1,848	2.32
Grafton State Hospital	1,897,711	314,128	2,211,839	1,162.90	136	923	0.49
Medfield State Hospital	1,554,074	254,370	1,808,444	1,100.03	238	609	0.37
Northampton State Hospital	877,499	171,062	1,048,561	1,071.05	210	511	0.52
State Infirmary	1,621,374	312,744	1,934,118	919.26	206	771	0.37
Taunton State Hospital	799,726	211,628	1,011,354	757.57	74	333	0.25
Westborough State Hospital	1,023,919	453,857	1,477,776	1,225.35	274	764	0.63
Worcester State Hospital	1,911,721	250,715	2,162,436	1,413.36	201	578	0.38
Michigan:							
Ionia State Hospital	456,151	120,949	577,100	1,170.59	300	360	0.73
Kalamazoo State Hospital	1,523,228	328,684	1,851,912	837.21	1,000	1,050	0.47
Newberry State Hospital	1,020,665	†	†	†	410	780	0.77
Pontiac State Hospital	1,223,289	246,251	1,469,540	996.97	400	590	0.40
State Psychopathic Hospital	79,043	17,315	96,358	1,703.34	.....	.....	.....
Traverse City State Hospital	1,015,530	272,968	1,288,498	723.88	560	883	0.50
Minnesota:							
Anoka State Asylum	798,500	88,076	886,576	1,022.58	400	693	0.80
Fergus Falls State Hospital	1,154,266	262,585	1,416,851	878.29	803	1,075	0.67
Hastings State Asylum	810,000	111,530	921,530	975.16	548	748	0.79
Rochester State Hospital	896,190	407,257	1,303,447	942.48	900	1,400	1.01
St Peter State Hospital‡	1,222,965	280,999	1,503,964	1,128.26	†	993	0.74
Willmar State Asylum	492,964	27,272	520,236	7,882.36	407	494	7.48
Mississippi:							
East Mississippi Insane Hospital†	.....	.....	.....	.....	.....	.....	.....
Mississippi State Insane Hospital‡	2,000,000	100,000	2,100,000	1,338.43	500	1,600	1.02
Missouri:							
State Hospital No. 1	800,000	75,000	875,000	686.27	200	736	0.58
State Hospital No. 2	575,778	115,025	690,803	395.42	400	819	0.47
State Hospital No. 3	595,250	376,104	968,354	770.98	520	866	0.69
State Hospital No. 4	1,000,000	50,000	1,050,000	1,400.00	700	875	1.17

* Based upon average daily number of patients in hospital during the last year.
† Data not available. ‡ 1919 data.

Table II—Value and acreage of plants of state hospitals for mental diseases as reported by superintendents—Continued

HOSPITAL	Value of Property				Acreage		
	Real estate	Personal property	Total	Per patient*	Under cultivation	Total	Per patient*
Montana:							
Montana State Hospital for the Insane†	.....	.....	.....	.....	.....	.....	.....
Nebraska:							
Hospital for the Insane of Nebraska (Norfolk)	†	†	$616,752	$985.23	340	455	0.73
Ingleside Hospital for the Insane	$800,000	$135,470	935,470	807.14	523	623	0.54
Nebraska Hospital for the Insane (Lincoln)	†	†	958,684	1,243.43	788	818	1.06
Nevada:							
Nevada Hospital for Mental Diseases	270,025	32,933	302,958	1,246.74	†	208	0.86
New Hampshire:							
New Hampshire State Hospital	941,059	193,115	1,134,174	904.44	102	469	0.37
New Jersey:‡							
The New Jersey State Hospital at Morris Plains	3,549,491	549,286	4,098,777	1,539.16	270	897	0.34
The New Jersey State Hospital at Trenton	2,052,930	378,132	2,431,062	1,302.12	250	462	0.25
New Mexico:							
State Hospital	281,893	43,043	324,936	955.69	120	300	0.88
New York:							
Binghamton State Hospital	2,900,000	325,000	3,225,000	1,189.16	747	1,363	0.50
Brooklyn State Hospital	1,410,000	120,000	1,530,000	1,772.89	124	220	0.25
Buffalo State Hospital	3,057,100	120,000	3,177,100	1,448.09	71	183	0.08
Central Islip State Hospital	3,133,028	260,970	3,393,998	685.52	275	994	0.20
Dannemora State Hospital	693,506	71,996	765,502	1,391.82	28	134	0.24
Gowanda State Homeopathic Hospital	840,050	241,899	1,081,949	842.64	482	500	0.39
Hudson River State Hospital	3,131,484	442,061	3,573,545	1,041.24	485	894	0.26
Kings Park State Hospital	4,670,609	530,153	5,200,762	1,172.40	165	835	0.19
Manhattan State Hospital	5,135,000	392,000	5,527,000	1,087.35	66	245	0.05
Matteawan State Hospital	1,180,563	82,192	1,262,755	1,390.70	435	482	0.53
Middletown State Homeopathic Hospital	1,890,895	145,000	2,035,895	924.15	288	543	0.25
Rochester State Hospital	1,019,290	69,030	1,088,320	683.19	190	269	0.17
St. Lawrence State Hospital	3,024,500	184,700	3,209,200	1,420.00	973	1,219	0.54
Utica State Hospital	1,790,300	200,000	1,990,300	1,180.49	950	1,402	0.83
Willard State Hospital	2,142,894	226,000	3,368,894	1,436.63	822	1,217	0.52

* Based upon average daily number of patients in hospital during the last year.
† Data not available. ‡ 1919 data.

Table II—Value and acreage of plants of state hospitals for mental diseases as reported by superintendents—Continued

HOSPITAL	Value of Property				Acreage		
	Real estate	Personal property	Total	Per patient*	Under cultivation	Total	Per patient*
North Carolina:							
State Hospital at Goldsboro	$343,980	$60,900	$404,880	$424.40	400	720	0.75
State Hospital (Morganton)†							
State Hospital (Raleigh)	2,000,000	129,950	2,129,950	2,115.14	300	1,420	1.41
State Hospital for Dangerous Insane†							
North Dakota:							
State Hospital for the Insane†							
Ohio:							
Athens State Hospital	1,325,216	287,569	1,612,785	1,195.54	200	964	0.71
Cleveland State Hospital	1,439,092	178,048	1,617,140	926.73	39	101	0.06
Columbus State Hospital	†	†	2,677,905	1,451.44	.....	304	0.16
Dayton State Hospital	1,183,774	257,415	1,441,189	1,157.58	693	767	0.62
Lima State Hospital for the Criminal Insane	2,122,300	98,448	2,220,748	2,721.50	434	574	0.70
Longview Hospital	1,500,000	109,341	1,609,341	1,030.31	44	180	0.12
Massillon State Hospital	1,305,029	246,026	1,551,055	844.80	1,170	1,374	0.75
Toledo State Hospital	1,516,590	239,340	1,755,930	972.28	537	757	0.42
Oklahoma:							
East Oklahoma Hospital	†	†	†	†	600	†	†
Central Oklahoma State Hospital	191,821	107,851	299,772	298.58	400	590	0.59
Western Oklahoma Hospital	171,464	80,197	251,661	524.29	508	1,760	3.67
Oregon:							
Eastern Oregon State Hospital†							
Oregon State Hospital	2,000,000	†	†	†	1,185	1,455	0.88
Pennsylvania:							
Homeopathic State Hospital (Allentown)	1,701,517	197,640	1,899,157	1,721.81	350	488	0.44
Pennsylvania State Lunatic Hospital (Harrisburg)	1,265,026	166,333	1,431,349	1,181.96	246	421	0.35
The State Asylum for the Chronic Insane of Pennsylvania (Wernersville)	1,139,110	145,000	1,284,110	1,389.73	460	975	1.06
State Hospital (Warren)	1,860,125	269,917	2,130,042	1,402.27	560	1,258	0.83
State Hospital for the Criminal Insane	1,742,689	61,329	1,804,018	4,567.13	170	1,270	3.22
State Hospital for the Insane (Danville)	1,415,934	289,282	1,705,216	1,011.40	446	664	0.39
State Hospital for the Insane (Norristown)	1,881,694	363,975	2,245,669	750.31	800	893	0.30
Rhode Island:							
State Hospital for Mental Diseases	1,500,000	225,000	1,725,000	1,220.81	95	150	0.11

* Based upon average daily number of patients in hospital during the last year.
† Data not available.

Table II—Value and acreage of plants of state hospitals for mental diseases as reported by superintendents—Concluded

HOSPITAL	Value of Property				Acreage		
	Real estate	Personal property	Total	Per patient*	Under cultivation	Total	Per patient*
South Carolina:							
State Hospital for the Insane	$1,617,375	$136,310	$1,753,685	$844.34	695	2,365	1.14
South Dakota:							
Asylum for Insane Indians	233,236	25,847	259,083	3,343.44	45	100	1.29
Yankton State Hospital	1,463,000	51,500	1,514,500	1,430.12	900	1,065	1.01
Tennessee:							
Central State Hospital	423,800	61,811	485,611	622.58	360	613	0.79
Eastern State Hospital	390,000	46,464	436,464	674.60	142	310	0.48
Western State Hospital†	.....	.....	.....	.....	.....	.....	.....
Texas:							
North Texas Hospital for the Insane†	.....	.....	.....	.....	.....	.....	.....
Southwestern Insane Asylum	890,000	261,078	1,151,078	587.58	450	600	0.31
State Lunatic Asylum	800,000	210,000	1,010,000	564.25	250	320	0.18
Utah:							
State Mental Hospital	449,000	80,000	529,000	827.86	148	320	0.50
Vermont:							
Vermont State Hospital for the Insane	453,798	170,859	624,657	854.52	150	750	1.03
Virginia:							
Central State Hospital	678,830	43,567	722,397	413.27	350	560	0.32
Eastern State Hospital	262,000	66,000	328,000	421.59	120	306	0.39
Southwestern State Hospital	280,423	68,834	349,257	504.71	80	256	0.37
Western State Hospital	400,000	25,000	425,000	352.99	200	588	0.49
Washington:							
Eastern State Hospital	691,943	114,334	806,277	707.88	850	†	†
Northern State Hospital	916,885	129,632	1,046,517	1,404.72	283	1,046	1.40
Western State Hospital	628,675	143,542	772,217	556.75	164	623	0.45
West Virginia:							
Huntington State Hospital	300,000	30,000	330,000	440.59	4	31	0.04
Spencer State Hospital	†	†	†	†	†	584	0.96
Weston State Hospital	1,500,000	100,000	1,600,000	1,486.99	75	335	0.31
Wisconsin:							
Central State Hospital for the Insane	220,447	42,701	263,148	2,631.48	50	72	0.72
Northern Hospital for the Insane	884,946	151,926	1,036,872	1,640.62	†	505	0.80
Wisconsin State Hospital for the Insane	848,508	168,159	1,016,667	1,552.16	†	408	0.62
Wyoming:							
Wyoming State Hospital for the Insane	†	†	†	†	200	920	3.85
Total reported	.....	.....	$197,261,782	$1,060.03	48,398	97,085	0.51

* Based upon average daily number of patients in hospital during the last year.
† Data not available.

Table III—Expenditures for maintenance of patients and for additions and improvements in state hospitals for mental diseases in the United States for the fiscal year 1918

HOSPITAL	End of fiscal year	Average daily patient population	Expenditures for Maintenance		Expenditures for additions, improvements, etc.
			Amount	Per capita	
Alabama	.....	†	$463,540.22	.....	None
The Bryce Hospital	Sept. 30, 1918	†	312,484.45	.....	.....
The Mt. Vernon Hospital	Sept. 30, 1918	†	151,055.77	.....	.....
Arizona	.....	†	124,610.86	.....	None
Arizona State Hospital	June 30, 1918	†	124,610.86	.....	.....
Arkansas	.....	2,011	341,392.36	$169.76	$15,496.77
State Hospital for Nervous Diseases	Mar. 31, 1918	2,011	341,392.36	169.76	15,496.77
California	.....	10,189	2,271,209.79	222.91	.....
Agnews State Hospital	June 30, 1918	1,638	395,343.18	241.36	25,157.81
Mendocino State Hospital	June 30, 1918	1,155	244,348.61	211.56	36,374.96
Napa State Hospital	June 30, 1918	2,324	524,791.88	225.81	83,772.78
Norwalk State Hospital	June 30, 1918	245	91,567.11	373.74	†
Southern California State Hospital	June 30, 1918	2,382	478,575.99	200.91	17,589.92
Stockton State Hospital	June 30, 1918	2,445	536,583.02	219.46	72,177.85
Colorado	.....	1,646	353,013.27	214.47	85,757.65
Colorado State Hospital	Nov. 30, 1918	1,646	353,013.27	214.47	85,757.65
Connecticut	.....	3,847	1,101,487.77	286.32	172,114.76
Connecticut State Hospital	Sept. 30, 1918	2,616	765,409.93	292.59	131,196.28
Norwich State Hospital for the Insane	Sept. 30, 1918	1,231	336,077.84	273.01	40,918.48
Delaware	.....	511	127,230.98	248.98	*33,287.54
Delaware State Hospital at Farnhurst	Nov. 30, 1918	511	127,230.98	248.98	*33,287.54
District of Columbia	.....	3,330	887,248.57	266.44	97,152.42
St. Elizabeths Hospital	June 30, 1918	3,330	887,248.57	266.44	97,152.42
Florida	.....	1,551	341,168.95	219.97	None
Florida Hospital for the Insane	Dec. 31, 1918	1,551	341,168.95	219.97	.....
Georgia	.....	4,078	870,018.23	213.34	77,878.12
Georgia State Sanitarium	Dec. 31, 1918	4,078	870,018.23	213.34	77,878.12
Idaho	.....	.....	.....	.....	.....
The Idaho Insane Asylum†	.....	.....	.....	.....	.....
Northern Idaho Sanitarium†	.....	.....	.....	.....	.....
Illinois‡	.....	17,203	3,648,056.17	212.06	158,237.43
Alton State Hospital	June 30, 1918	425	.....	331.64	.....
Anna State Hospital	June 30, 1918	1,785	.....	217.33	.....
Chester State Hospital	June 30, 1918	191	.....	282.95	.....
Chicago State Hospital	June 30, 1918	3,349	.....	201.98	.....
Elgin State Hospital	June 30, 1918	2,056	.....	206.72	.....
Jacksonville State Hospital	June 30, 1918	2,098	.....	188.04	.....
Kankakee State Hospital	June 30, 1918	3,289	.....	216.93	.....
Peoria State Hospital	June 30, 1918	2,325	.....	224.37	.....
Watertown State Hospital	June 30, 1918	1,685	.....	198.19	.....

* Estimated from biennial report. † Data not available.
‡ Data taken from annual report of Department of Public Welfare.

Table III—Expenditures for maintenance of patients and for additions and improvements in state hospitals for mental diseases in the United States for the fiscal year 1918—Continued

HOSPITAL	End of fiscal year	Average daily patient population	Expenditures for Maintenance		Expenditures for additions, improvements, etc.
			Amount	Per capita	
Indiana	.....	.....	.....	.....	.....
Central Indiana Hospital for the Insane	Sept. 30, 1918	1,502	$448,646.38	$298.74	$38,294.00
Eastern Indiana Hospital for the Insane	Sept. 30, 1918	871	204,584.37	234.96	8,431.78
Indiana Hospital for Insane Criminals†	.....	.....	.....	.....	.....
Northern Hospital for the Insane	Sept. 30, 1918	959	241,921.56	252.22	6,294.02
Southeastern Hospital for the Insane†	Sept. 30, 1918	1,166	252,858.32	216.86	58,314.66
Southern Indiana Hospital for the Insane†	.....	.....	.....	.....	.....
Iowa	.....	**4,576**	**945,040.12**	**206.52**	**114,079.09**
Cherokee State Hospital	June 30, 1918	1,113	*224,367.45	201.59	*20,321.18
Clarinda State Hospital	June 30, 1918	1,195	246,388.59	206.18	24,453.31
Independence State Hospital	June 30, 1918	1,148	242,067.21	210.86	26,601.91
Mount Pleasant State Hospital	June 30, 1918	1,120	*232,216.87	207.34	*42,702.69
The Reformatory†	.....	.....	.....	.....	.....
Kansas	.....	**3,067**	**634,749.02**	**206.96**	**38,100.90**
Hospital for the Dangerous Insane	June 30, 1918	55	10,000.00	181.82	None
Larned State Hospital	June 30, 1918	*112	32,374.09	289.05	10,117.36
Osawatomie State Hospital	June 30, 1918	1,345	268,417.66	199.57	13,529.63
Topeka State Hospital	June 30, 1918	1,555	323,957.27	208.33	14,453.91
Kentucky†	.....	.....	.....	.....	.....
Central State Hospital	.....	.....	.....	.....	.....
Eastern State Hospital	.....	.....	.....	.....	.....
Western State Hospital	.....	.....	.....	.....	.....
Louisiana*	.....	**2,578**	**435,202.37**	**168.81**	**7,407.24**
East Louisiana Hospital for the Insane	Mar. 31, 1918	1,678	265,461.68	158.20	None
Louisiana Hospital for the Insane	Mar. 31, 1918	900	169,740.69	188.60	7,407.24
Maine	.....	**1,735**	**522,511.12**	**301.16**	**119,823.12**
Augusta State Hospital	June 30, 1918	1,034	305,203.22	295.17	113,035.39
Bangor State Hospital	June 30, 1918	701	217,307.90	310.00	6,787.73
Maryland	.....	.....	.....	.....	.....
Crownsville State Hospital†	.....	.....	.....	.....	.....
Eastern Shore State Hospital	Sept. 30, 1918	240	91,595.40	381.65	None
Spring Grove State Hospital	Sept. 30, 1918	792	206,927.72	261.27	4,122.52
Springfield State Hospital	Sept. 30, 1919	†	383,383.15	.....	4,409.09

* Estimated from biennial report.
† Data not available.

Table III—Expenditures for maintenance of patients and for additions and improvements in state hospitals for mental diseases in the United States for the fiscal year 1918—Continued

HOSPITAL	End of fiscal year	Average daily patient population	Expenditures for Maintenance		Expenditures for additions, improvements, etc.
			Amount	Per capita	
Massachusetts*	.....	**13,598**	**$4,922,070.61**	**$361.97**	**$436,298.80**
Boston State Hospital	Sept. 30, 1918	1,597	768,278.65	480.98	151,053.39
Danvers State Hospital	Sept. 30, 1918	1,502	556,364.55	370.41	8,251.30
Foxborough State Hospital	Sept. 30, 1918	387	213,215.56	550.74	115,607.58
Gardner State Colony	Sept. 30, 1918	796	257,705.66	323.71	11,189.70
Grafton State Hospital	Sept. 30, 1918	1,902	643,247.73	338.24	94,506.70
Medfield State Hospital	Sept. 30, 1918	1,644	516,090.75	313.88	19,833.72
Northampton State Hospital	Sept. 30, 1918	979	305,966.33	312.39	15,596.45
State Infirmary	Sept. 30, 1918	720	238,078.72	330.44	None
Taunton State Hospital	Sept. 30, 1918	1,335	451,869.38	338.47	None
Westborough State Hospital	Sept. 30, 1918	1,206	483,733.25	401.11	13,593.13
Worcester State Hospital	Sept. 30, 1918	1,530	487,520.03	318.60	6,666.83
Michigan	.....	**7,031**	**1,958,523.75**	**278.56**	**170,221.68**
Ionia State Hospital	June 30, 1918	493	134,492.80	272.80	4,848.82
Kalamazoo State Hospital	June 30, 1918	2,212	612,131.38	276.73	61,176.94
Newberry State Hospital	June 30, 1918	1,015	277,678.94	273.58	43,919.45
Pontiac State Hospital	June 30, 1918	1,474	421,222.76	285.77	25,799.74
State Psychopathic Hospital	June 30, 1918	57	46,407.25	814.16	None
Traverse City State Hospital	June 30, 1918	1,780	466,590.62	262.13	34,476.73
Minnesota	.....	**6,207**	**1,123,397.35**	**180.99**	**439,645.61**
Anoka State Asylum	July 31, 1918	867	117,626.38	135.67	88,259.05
Fergus Falls State Hospital	July 31, 1918	1,613	319,487.32	198.07	38,924.07
Hastings State Asylum	July 31, 1918	945	146,604.75	155.14	86,672.57
Rochester State Hospital	July 31, 1918	1,383	234,955.94	169.89	53,544.54
St. Peter State Hospital	July 31, 1918	1,333	259,531.68	194.70	34,683.52
Willmar State Asylum	July 31, 1918	66	45,191.28	684.72	137,561.86
Mississippi	.....	.....	.....	.....	.....
East Mississippi Insane Hospital†	.....	.....	.....	.....	.....
Mississippi State Insane Hospital	June 30, 1918	1,622	353,715.69	218.07	30,764.02
Missouri	.....	**5,028**	**1,062,136.47**	**211.24**	**12,026.93**
State Hospital No. 1	Dec. 31, 1918	1,275	292,451.56	229.37	None
State Hospital No. 2	Dec. 31, 1918	1,747	352,538.86	201.80	11,421.59
State Hospital No. 3	Dec. 31, 1918	1,256	266,203.34	211.95	None
State Hospital No. 4	Dec. 31, 1918	750	150,942.71	201.26	605.34
Montana	.....	**‡1,151**	**‡333,970.00**	**‡290.16**	**‡32,650.00**
Montana State Hospital for the Insane	Nov. 30, 1918	‡1,151	‡333,970.00	‡290.16	‡32,650.00
Nebraska	.....	**2,556**	**573,257.01**	**224.28**	**138,588.01**
Hospital for the Insane of Nebraska (Norfolk)	Nov. 30, 1918	626	‡139,902.03	†223.49	‡47,956.49
Ingleside Hospital for the Insane	Nov. 30, 1918	1,159	‡264,136.98	†227.90	‡38,193.52
Nebraska Hospital for the Insane (Lincoln)	Nov. 30, 1918	771	169,218.00	219.48	52,438.00

* Financial year ends November 30.
† Data not available. ‡ Estimated.

Table III—Expenditures for maintenance of patients and for additions and improvements in state hospitals for mental diseases in the United States for the fiscal year 1918—Continued

HOSPITAL	End of fiscal year	Average daily patient population	Expenditures for Maintenance		Expenditures for additions, improvements, etc.
			Amount	Per capita	
Nevada	.....	**243**	**‡$57,782.38**	**‡$237.79**	**‡$2,261.75**
Nevada Hospital for Mental Diseases	Dec. 31, 1918	243	‡57,782.38	‡237.79	‡2,261.75
New Hampshire	.....	**1,254**	**382,515.61**	**305.04**	**2,433.73**
New Hampshire State Hospital	Aug. 31, 1918	1,254	382,515.61	305.04	2,433.73
New Jersey	.....	**4,530**	**1,307,376.71**	**288.60**	**13,367.20**
The New Jersey State Hospital at Morris Plains	June 30, 1919	2,663	786,245.61	295.25	13,367.20
The New Jersey State Hospital at Trenton	June 30, 1919	1,867	521,131.10	279.13	None
New Mexico	.....	**340**	**90,580.76**	**266.41**	**None**
State Hospital	Oct. 31, 1918	340	90,580.76	266.41	None
New York	.....	**36,500**	**9,651,664.26**	**264.43**	**881,598.42**
Binghamton State Hospital	June 30, 1918	2,712	707,063.90	260.71	68,484.96
Brooklyn State Hospital	June 30, 1918	863	279,236.16	323.56	349,459.37
Buffalo State Hospital	June 30, 1918	2,194	584,588.56	266.44	13,364.29
Central Islip State Hospital	June 30, 1918	4,951	1,237,517.03	249.95	94,691.16
Dannemora State Hospital	June 30, 1918	550	184,682.40	335.79	24,217.20
Gowanda State Homeopathic Hospital	June 30, 1918	1,284	320,918.12	249.93	11,735.94
Hudson River State Hospital	June 30, 1918	3,432	964,195.27	280.94	7,701.58
Kings Park State Hospital	June 30, 1918	4,436	1,104,941.34	249.08	98,629.00
Manhattan State Hospital	June 30, 1918	5,083	1,365,396.14	268.62	98,827.81
Matteawan State Hospital	June 30, 1918	908	274,827.72	302.67	10,442.01
Middletown State Homeopathic Hospital	June 30, 1918	2,203	537,328.07	243.90	34,979.54
Rochester State Hospital	June 30, 1918	1,593	429,463.98	269.59	32,221.20
St. Lawrence State Hospital	June 30, 1918	2,260	579,135.02	256.25	21,531.36
Utica State Hospital	June 30, 1918	1,686	441,715.80	261.99	8,073.15
Willard State Hospital	June 30, 1918	2,345	640,654.75	273.20	7,239.85
North Carolina	.....	**3,291**	**706,448.37**	**214.66**	**142,613.10**
State Hospital at Goldsboro	Nov. 30, 1918	954	165,243.76	173.21	56,052.55
State Hospital (Morganton)	Nov. 30, 1918	1,330	307,899.18	231.50	9,052.84
State Hospital (Raleigh)	Nov. 30, 1918	1,007	233,305.43	231.68	77,507.71
State Hospital for Dangerous Insane†	.....	.....	.....	.....	.....
North Dakota	.....	.....	.....	.....	.....
State Hospital for the Insane†	.....	.....	.....	.....	.....
Ohio	.....	**12,204**	**2,441,586.51**	**200.06**	**198,250.13**
Athens State Hospital	June 30, 1918	1,349	263,139.60	195.06	6,929.18
Cleveland State Hospital	June 30, 1918	1,745	339,781.90	194.72	8,473.67
Columbus State Hospital	June 30, 1918	1,845	365,807.30	198.27	73,078.61
Dayton State Hospital	June 30, 1918	1,245	254,987.60	204.81	14,447.57
Lima State Hospital for the Criminal Insane	June 30, 1918	816	198,241.57	242.94	11,652.88
Longview Hospital	June 30, 1918	1,562	287,677.76	184.17	None
Massillon State Hospital	June 30, 1918	1,836	322,477.44	175.64	77,190.37
Toledo State Hospital	June 30, 1918	1,806	409,473.34	226.73	6,477.90

† Data not available. ‡ Estimated.

Table III—Expenditures for maintenance of patients and for additions and improvements in state hospitals for mental diseases in the United States for the fiscal year 1918—Continued

HOSPITAL	End of fiscal year	Average daily patient population	Expenditures for Maintenance		Expenditures for additions, improvements, etc.
			Amount	Per capita	
Oklahoma	.....	.....	.....	.....	.....
East Oklahoma Hospital†	.....	.....	.....	.....	.....
Central Oklahoma State Hospital	June 30, 1918	1,004	$174,820.05	$174.12	$82,537.14
Western Oklahoma Hospital	June 30, 1918	480	119,006.88	247.93	10,692.72
Oregon	.....	**2,134**	**453,534.51**	**212.52**	**85,817.48**
Eastern Oregon State Hospital*	Sept. 30, 1918	488	104,930.65	215.02	9,427.23
Oregon State Hospital	Sept. 30, 1918	1,646	348,603.86	211.79	76,390.25
Pennsylvania	.....	**9,831**	**2,744,153.66**	**279.13**	**324,525.39**
Homeopathic State Hospital (Allentown)	May 31, 1918	1,103	293,888.14	266.44	53,573.89
Pennsylvania State Lunatic Hospital (Harrisburg)	May 31, 1918	1,211	325,778.94	269.02	1,715.91
The State Asylum for the Chronic Insane of Pennsylvania (Wernersville)	May 31, 1918	924	192,661.32	208.51	124,839.41
State Hospital (Warren)	May 31, 1918	1,519	438,505.90	288.68	12,953.03
State Hospital for the Criminal Insane	May 31, 1918	395	151,376.87	383.23	29,291.91
State Hospital for the Insane (Danville)	May 31, 1918	1,686	448,786.80	266.18	16,712.58
State Hospital for the Insane (Norristown)	May 31, 1918	2,993	893,155.69	298.41	85,438.66
Rhode Island	.....	**1,413**	**364,225.47**	**257.77**	**72,849.56**
State Hospital for Mental Diseases	Dec. 31, 1918	1,413	364,225.47	257.77	72,849.56
South Carolina	.....	**2,077**	**494,231.55**	**237.95**	**137,143.45**
State Hospital for the Insane	Dec. 31, 1918	2,077	494,231.55	237.95	137,143.45
South Dakota	.....	.....	.....	.....	.....
Asylum for Insane Indians	June 30, 1918	77	33,548.44	435.69	None
Yankton State Hospital	June 30, 1918	1,059	256,809.39	242.50	39,765.98
Tennessee	.....	**2,184**	**387,158.86**	**177.27**	**53,678.79**
Central State Hospital	June 30, 1918	780	112,961.14	144.82	22,102.98
Eastern State Hospital	June 30, 1918	647	129,987.89	200.91	None
Western State Hospital	June 30, 1918	757	144,209.83	190.50	31,575.81
Texas	.....	**5,656**	**1,110,970.85**	**196.42**	**264,394.25**
North Texas Hospital for the Insane	Aug. 31, 1918	1,907	338,394.59	177.45	19,990.94
Southwestern Insane Asylum	Aug. 31, 1918	1,959	404,044.79	206.25	177,124.45
State Lunatic Asylum	Aug. 31, 1918	1,790	368,531.47	205.88	67,278.86
Utah	.....	**639**	**116,693.83**	**182.62**	**6,205.37**
State Mental Hospital	Nov. 30, 1918	639	116,693.83	182.62	6,205.37
Vermont	.....	**731**	**201,826.66**	**276.10**	**None**
Vermont State Hospital for the Insane	June 30, 1918	731	201,826.66	276.10	None

* Estimated from biennial report. † Data not available.

Table III—Expenditures for maintenance of patients and for additions and improvements in state hospitals for mental diseases in the United States for the fiscal year 1918—Concluded

HOSPITAL	End of fiscal year	Average daily patient population	Expenditures for Maintenance		Expenditures for additions, improvements, etc.
			Amount	Per capita	
Virginia	.....	4,422	$786,646.01	$177.89	$24,236.05
Central State Hospital	Sept. 30, 1918	1,748	309,213.77	176.90	10,814.33
Eastern State Hospital	Sept. 30, 1918	778	148,813.52	191.28	4,226.57
Southwestern State Hospital	Sept. 30, 1918	692	128,954.46	186.35	4,356.52
Western State Hospital	Sept. 30, 1918	1,204	199,664.26	165.83	4,838.63
Washington	.....	3,271	561,189.10	171.56	126,787.49
Eastern State Hospital*	Sept. 30, 1918	1,139	189,494.97	166.37	12,852.75
Northern State Hospital*	Sept. 30, 1918	745	133,398.16	179.06	85,825.31
Western State Hospital*	Sept. 30, 1918	1,387	238,295.97	171.81	28,109.43
West Virginia	.....	2,432	425,683.65	175.03	39,633.67
Huntington State Hospital	June 30, 1918	749	121,340.41	162.00	7,187.19
Spencer State Hospital	June 30, 1918	607	108,913.65	179.43	7,243.02
Weston State Hospital	June 30, 1918	1,076	195,429.59	181.63	25,203.46
Wisconsin	.....	1,387	407,644.28	293.90	10,220.26
Central State Hospital for the Insane	June 30, 1918	100	38,449.26	384.49	6,706.86
Northern Hospital for the Insane	June 30, 1918	632	179,576.63	284.14	1,304.09
Wisconsin State Hospital for the Insane	June 30, 1918	655	189,618.39	289.49	2,209.31
Wyoming	.....	239	61,558.68	257.57	17,325.14
Wyoming State Hospital for the Insane	Sept. 30, 1918	239	61,558.68	257.57	17,325.14
Total reported	.....	196,443	$48,561,124.05	244.21	$5,070,856.60

* Estimated from biennial report.

Table IV—Comparison of cost of maintenance of patients in state hospitals for mental diseases for the fiscal years 1917 and 1918

(States for which no data for 1918 were obtained are omitted.)

STATE	Amount		Per Capita of Average Daily Population		Increase in 1918	
	1917	1918	1917	1918	Amount	Per capita
Alabama	$420,511.97	$463,540.22	$184.35	z	$43,028.25	z
Arizona	92,406.17	124,610.86	187.44	z	32,204.69	z
Arkansas	348,953.60	341,392.36	173.52	$169.76	§7,561.24	§3.76
California	2,105,368.71	2,271,209.79	208.56	222.91	165,841.08	14.35
Colorado	344,391.56	353,013.27	215.78	214.47	8,621.71	§1.31
Connecticut	918,902.18	1,101,487.77	238.12	286.32	182,585.59	48.20
Delaware	105,862.26	127,230.98	210.04	248.98	21,368.72	38.94
District of Columbia	779,000.00	887,248.57	242.75	266.44	108,248.57	23.69
Florida	323,495.62	341,168.95	211.57	219.97	17,673.33	8.40
Georgia	795,817.94	870,018.23	196.21	213.34	74,200.29	17.13
Illinois*	3,314,322.86	3,595,012.72	188.07	211.32	280,689.86	23.25
Iowa*	885,544.68	945,040.12	192.76	206.52	59,495.44	13.76
Kansas*	521,041.81	624,749.02	171.85	207.42	103,707.21	35.57
Louisiana†	390,497.47	435,202.37	153.56	168.81	44,704.90	15.25
Maine	519,084.15	522,511.12	306.97	301.16	3,426.97	§5.81
Massachusetts*	4,045,722.48	4,922,070.61	298.75	361.97	876,348.13	63.22
Michigan	1,650,713.48	1,958,523.75	237.24	278.56	307,810.27	41.32
Minnesota	1,047,353.58	1,123,397.35	172.35	180.99	76,043.77	8.64
Missouri	1,037,721.79	1,062,136.87	207.84	211.24	24,415.08	3.40
Montana	295,000.00	†333,970.00	245.83	†290.16	38,970.00	44.33
Nebraska	519,018.26	573,257.01	207.44	224.28	54,238.75	16.84
Nevada	58,744.55	†57,782.38	235.92	†237.79	§962.17	1.87
New Hampshire	318,533.41	382,515.61	264.12	305.04	63,982.20	40.92
New Jersey	1,109,208.01	‡1,307,376.71	251.69	‡288.60	198,168.70	36.91
New Mexico	68,089.45	90,580.76	214.12	266.41	22,491.31	52.29
New York	7,872,857.93	9,651,664.26	220.89	264.43	1,778,806.33	43.54
North Carolina*	622,312.77	706,448.37	179.86	214.66	84,135.60	34.80
Ohio	1,954,811.51	2,441,586.51	161.55	200.06	486,775.00	38.51
Oregon	344,580.53	453,534.51	163.85	212.52	108,953.98	48.67
Pennsylvania	2,345,289.91	2,744,153.66	242.58	279.13	398,863.75	36.55
Rhode Island	286,309.36	364,225.47	202.91	257.77	77,916.11	54.86
South Carolina	410,271.79	494,231.55	198.20	237.95	83,959.76	39.75
South Dakota	246,000.00	256,809.39	232.29	242.50	10,809.39	10.21
Tennessee	365,634.56	387,158.86	165.60	177.27	21,524.30	11.67
Texas	879,142.40	1,110,970.85	156.63	196.42	231,828.45	39.79
Utah	107,310.00	116,693.83	178.85	182.62	9,383.83	3.77
Vermont	180,198.00	201,826.66	240.58	276.10	21,628.66	35.52
Virginia	677,853.90	786,646.01	135.90	177.89	108,792.11	41.99
Washington	630,580.62	†561,189.10	193.91	†171.56	§69,391.52	§22.35
West Virginia	425,574.65	425,683.65	173.63	175.03	109.00	1.40
Wisconsin	406,263.00	407,644.28	296.33	293.90	1,381.28	§2.43
Wyoming	41,479.12	61,588.68	186.84	257.57	20,109.56	70.73

* Not including hospital for criminal insane.
† Estimated. ‡ 1919 data. § Decrease. z Data not available.

Table V—Movement of patient population in state hospitals

HOSPITAL	On books at beginning of fiscal year	Admissions			
		Total	First admissions	Readmissions	Transfers
Alabama	**2,726**	**929**	.....	.....	.....
The Bryce Hospital	1,881	657	.....	.....	.....
The Mt. Vernon Hospital	845	272	.....	.....	.....
Arizona†	.....	.....	.....	.....	.....
Arizona State Hospital	.....	.....	.....	.....	.....
Arkansas	**2,018**	**1,196**	**938**	**258**	.....
State Hospital for Nervous Diseases	2,018	1,196	938	258	.....
California	**10,294**	**3,057**	.....	.....	.....
Agnews State Hospital	1,628	514	.....	.....	.....
Mendocino State Hospital	1,109	206	.....	.....	.....
Napa State Hospital	2,494	647	.....	.....	.....
Norwalk State Hospital	237	72	.....	.....	.....
Southern California State Hospital	2,374	862	.....	.....	.....
Stockton State Hospital	2,452	756	.....	.....	.....
Colorado	**1,648**	**409**	**403**	**6**	.....
Colorado State Hospital	1,648	409	403	6	.....
Connecticut	**3,870**	.....	.....	.....	.....
Connecticut State Hospital	2,662	453	387	66	.....
Norwich State Hospital for the Insane	1,208	†	†	†	†
Delaware	**504**	**129**	**108**	**21**	.....
Delaware State Hospital at Farnhurst	504	129	108	21	.....
District of Columbia	**3,244**	**1,054**	.....	.....	.....
St. Elizabeths Hospital	3,244	1,054	.....	.....	.....
Florida	**1,581**	**693**	.....	.....	.....
Florida Hospital for the Insane	1,581	693	.....	.....	.....
Georgia	**4,070**	**1,251**	**1,035**	**216**	.....
Georgia State Sanitarium	4,070	1,251	1,035	216	.....
Idaho†	.....	.....	.....	.....	.....
The Idaho Insane Asylum	.....	.....	.....	.....	.....
Northern Idaho Sanitarium	.....	.....	.....	.....	.....
Illinois	**18,534**	**6,189**	**4,671**	**957**	**561**
Alton State Hospital	450	513	166	13	334
Anna State Hospital	1,899	617	475	132	10
Chester State Hospital	221	33	31	2	.....
Chicago State Hospital	3,627	1,789	1,496	230	63
Elgin State Hospital	2,282	908	731	149	28
Jacksonville State Hospital	2,284	486	375	88	23
Kankakee State Hospital	3,427	944	759	157	28
Peoria State Hospital	2,505	485	309	101	75
Watertown State Hospital	1,839	414	329	85	.....
Indiana	.....	.....	.....	.....	.....
Central Indiana Hospital for the Insane	1,635	115	.....	.....	.....
Eastern Indiana Hospital for the Insane	907	98	.....	.....	.....
Indiana Hospital for Insane Criminals	176	20	20	.....	.....
Northern Hospital for the Insane	1,185	240	.....	.....	.....
Southeastern Hospital for the Insane	1,226	266	223	43	.....
Southern Indiana Hospital for the Insane†	.....	.....	.....	.....	.....

†Data not available.

for mental diseases in the United States for the fiscal year 1918

Total under treatment during year	Discharges								On books at end of fiscal year
	Total	Recovered	Improved	Unimproved	Condition unascertained	No psychosis	Transferred to other hospitals	Died	
3,655	1,092	.....	.....	.....	549	.....	8	535	2,563
2,538	825	.....	.....	.....	471	.....	4	350	1,713
1,117	267	.....	.....	.....	78	.....	4	185	850
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
3,214	450	36	9	8	1	6	.....	390	2,764
3,214	450	36	9	8	1	6	.....	390	2,764
13,351	2,694	703	463	74	384	10	11	1,049	10,657
2,142	466	131	75	8	30	6	1	215	1,676
1,315	179	41	13	17	26	.....	.....	82	1,136
3,141	517	33	162	11	111	2	3	195	2,624
309	65	10	14	1	15	.....	1	24	244
3,236	786	265	126	20	102	2	1	270	2,450
3,208	681	223	73	17	100	.....	5	263	2,527
2,057	316	53	62	7	.....	1	.....	193	1,741
2,057	316	53	62	7	.....	1	.....	193	1,741
.....	.....	.....	.....	.....	.....	.....	.....	474	3,871
3,115	523	84	106	42	.....	3	11	277	2,592
†	†	†	†	†	†	†	†	197	1,279
633	134	28	14	16	.....	4	.....	72	499
633	134	28	14	16	.....	4	.....	72	499
4,298	923	281	131	123	.....	55	.....	333	3,375
4,298	923	281	131	123	.....	55	.....	333	3,375
2,274	871	98	112	.....	163	9	14	475	1,403
2,274	871	98	112	.....	163	9	14	475	1,403
5,321	1,359	146	342	151	2	22	.....	696	3,962
5,321	1,359	146	342	151	2	22	.....	696	3,962
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
24,723	6,850	561	2,342	571	141	87	733	2,315	17,873
963	325	4	133	33	.....	.....	22	133	638
2,516	659	43	219	116	.....	18	56	207	1,857
254	128	.....	.....	.....	123	.....	.....	5	126
5,416	2,029	140	870	61	.....	14	293	651	3,387
3,190	919	121	243	197	.....	.....	67	291	2,271
2,770	587	70	174	11	18	3	100	211	2,183
4,371	972	79	288	73	.....	3	119	410	3,399
2,990	672	20	219	34	.....	46	73	280	2,318
2,253	559	84	196	46	.....	3	3	227	1,694
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1,750	261	51	63	7	.....	.....	.....	140	1,489
1,005	105	27	22	1	.....	.....	1	54	900
196	16	11	.....	.....	.....	.....	.....	5	180
1,425	407	44	166	71	.....	2	.....	124	1,018
1,492	259	27	72	22	.....	.....	.....	138	1,233
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

Table V—Movement of patient population in state hospitals for mental

HOSPITAL	On books at beginning of fiscal year	Admissions			
		Total	First admissions	Re-admissions	Transfers
Iowa	5,119	1,140	944	171	25
Cherokee State Hospital	1,246	291	266	23	2
Clarinda State Hospital	1,379	318	216	95	7
Independence State Hospital	1,379	300	252	33	15
Mount Pleasant State Hospital	1,115	231	210	20	1
The Reformatory†	.....	.....	.....	.....	.....
Kansas	3,442	667	.....	.....	.....
Hospital for the Dangerous Insane	41	29	29	.....	.....
Larned State Hospital¶	113	11	.....	.....	10
Osawatomie State Hospital	1,679	254	.....	.....	.....
Topeka State Hospital	1,609	373	.....	.....	.....
Kentucky	.....	.....	.....	.....	.....
Central State Hospital	1,792	451	382	67	2
Eastern State Hospital	1,440	442	376	59	7
Western State Hospital†	.....	.....	.....	.....	.....
Louisiana	2,531	443	.....	.....	.....
East Louisiana Hospital for the Insane¶	1,648	218	.....	.....	.....
Louisiana Hospital for the Insane	883	225	.....	.....	.....
Maine	1,721	558	451	105	2
Augusta State Hospital	1,089	294	236	58	.....
Bangor State Hospital	632	264	215	47	2
Maryland	.....	.....	.....	.....	.....
Crownsville State Hospital†	.....	.....	.....	.....	.....
Eastern Shore State Hospital	254	69	69	.....	.....
Spring Grove State Hospital	794	169	113	20	36
Springfield State Hospital§	1,510	359	189	80	90
Massachusetts	15,889	5,684	3,680	1,546	458
Boston State Hospital	1,795	2,198	1,742	442	14
Bridgewater State Hospital	854	64	47	15	2
Danvers State Hospital	1,756	734	480	237	17
Foxborough State Hospital	363	172	30	17	125
Gardner State Colony	853	35	.....	.....	35
Grafton State Hospital	1,988	201	17	42	142
Medfield State Hospital	1,655	174	33	106	35
Northampton State Hospital	1,119	404	316	88	.....
State Infirmary	734	92	25	5	62
Taunton State Hospital	1,532	482	349	131	2
Westborough State Hospital	1,469	495	255	222	18
Worcester State Hospital	1,771	633	386	241	6
Michigan	6,991	2,482	1,568	635	221
Ionia State Hospital	483	60	49	2	9
Kalamazoo State Hospital*	2,220	950	548	382	20
Newberry State Hospital*	1,004	279	197	81	1
Pontiac State Hospital*	1,498	444	307	91	46
State Psychopathic Hospital*	54	233	225	5	3
Traverse City State Hospital*	1,732	‡516	245	74	142

* Includes other than insane. † Data not available. ‡ Includes 55 undistributed cases.

diseases in the United States for the fiscal year 1918—Continued

Total under treatment during year	Discharges								On books at end of fiscal year
	Total	Recovered	Improved	Unimproved	Condition unascertained	No psychosis	Transferred to other hospitals	Died	
6,259	993	167	20	63	140	7	106	490	5,266
1,537	190	28	1	1	22	2	19	117	1,347
1,697	266	64	19	.....	.....	5	30	148	1,431
1,679	342	51	.....	.....	118	.....	50	123	1,337
1,346	195	24	.....	62	.....	.....	7	102	1,151
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
4,109	783	138	221	11	10	4	24	375	3,326
70	5	5	.....	.....	.....	.....	.....	.....	65
124	13	.....	.....	.....	10	.....	1	2	111
1,933	417	76	163	1	.....	.....	19	158	1,516
1,982	348	57	58	10	.....	4	4	215	1,634
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2,243	472	60	171	18	.....	.....	1	222	1,686
1,882	483	45	175	20	.....	.....	3	240	1,399
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2,974	372	26	51	16	143	.....	.....	136	2,602
1,866	181	26	51	16	.....	.....	.....	88	1,685
1,108	191	.....	.....	.....	143	.....	.....	48	917
2,279	399	47	58	22	.....	36	1	235	1,880
1,383	243	44	48	7	.....	14	1	129	1,140
896	156	3	10	15	.....	22	.....	106	740
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
323	86	8	28	6	1	.....	.....	40	240
963	175	43	24	18	.....	1	1	88	788
1,869	395	83	100	13	.....	22	.....	177	1,474
21,573	5,115	338	904	1,212	.....	488	458	1,715	16,458
3,993	2,074	65	372	911	.....	407	17	302	1,919
918	96	14	1	7	.....	1	.....	¶73	822
2,490	661	41	171	49	.....	9	161	230	1,829
535	82	3	9	7	.....	.....	27	36	453
888	40	.....	12	2	.....	.....	10	16	848
2,189	233	.....	26	19	.....	.....	14	174	1,956
1,829	171	10	19	16	.....	1	4	121	1,658
1,523	354	64	63	32	.....	6	43	146	1,169
826	86	.....	4	8	.....	.....	12	62	740
2,014	414	43	71	40	.....	13	60	187	1,600
1,964	393	42	90	46	.....	10	46	159	1,571
2,404	511	56	66	75	.....	41	64	209	1,893
9,473	2,364	240	498	243	264	158	133	828	7,109
543	52	19	6	4	.....	6	.....	¶17	491
3,170	963	53	177	65	260	52	58	298	2,207
1,283	263	37	90	28	4	16	2	86	1,020
1,942	467	62	86	53	.....	28	25	213	1,475
287	226	31	70	65	.....	5	43	12	61
2,248	393	38	69	28	.....	51	5	202	1,855

§ 1919 data. ¶ Estimated from biennial report.

Table V—Movement of patient population in state hospitals for mental

HOSPITAL	On books at beginning of fiscal year	Admissions			
		Total	First admissions	Re-admissions	Transfers
Minnesota	**6,253**	**2,036**	**1,316**	**422**	**298**
Anoka State Asylum	866	34	.....	7	27
Fergus Falls State Hospital	1,738	502	437	65	.....
Hastings State Asylum	905	142	.....	20	122
Rochester State Hospital	1,396	671	484	180	7
St. Peter State Hospital	1,348	589	395	143	51
Willmar State Asylum	None	98	.....	7	91
Mississippi	.....	.....	.....	.....	.....
East Mississippi Insane Hospital†	.....	.....	.....	.....	.....
Mississippi State Insane Hospital*	1,624	619	.....	.....	.....
Missouri	**5,296**	**1,304**	.....	.....	.....
State Hospital No. 1	1,280	315	274	41	.....
State Hospital No. 2	1,858	417	353	64	.....
State Hospital No. 3	1,401	380	.....	.....	.....
State Hospital No. 4	757	192	176	16	.....
Montana	**1,091**	**590**	.....	.....	.....
Montana State Hospital for the Insane*	1,091	590	.....	.....	.....
Nebraska	**2,558**	**557**	**436**	**121**	.....
Hospital for the Insane of Nebraska (Norfolk)	654	155	139	16	.....
Ingleside Hospital for the Insane	1,143	169	129	40	.....
Nebraska Hospital for the Insane (Lincoln)	761	233	168	65	.....
Nevada	**252**	**66**	.....	.....	.....
Nevada Hospital for Mental Diseases	252	66	.....	.....	.....
New Hampshire	**1,233**	**446**	.....	.....	.....
New Hampshire State Hospital	1,233	446	.....	.....	.....
New Jersey**	**4,791**	**1,349**	**1,154**	**195**	.....
The New Jersey State Hospital at Morris Plains	2,723	‡613	¶545	68	.....
The New Jersey State Hospital at Trenton	2,068	736	609	127	.....
New Mexico	**328**	**134**	.....	.....	.....
State Hospital	328	134	.....	.....	.....
New York	**37,790**	**9,754**	**6,956**	**1,927**	**871**
Binghamton State Hospital	2,815	369	219	65	85
Brooklyn State Hospital	890	609	491	99	19
Buffalo State Hospital	2,262	477	358	103	16
Central Islip State Hospital	5,099	1,651	1,202	329	120
Dannemora State Hospital	546	60	54	6	.....
Gowanda State Homeopathic Hospital	1,312	264	210	51	3
Hudson River State Hospital	3,499	690	512	152	26
Kings Park State Hospital	4,638	1,146	780	268	98
Manhattan State Hospital	5,329	2,275	1,707	399	169
Matteawan State Hospital	887	128	105	18	5
Middletown State Homeopathic Hospital	2,307	283	187	74	22
Rochester State Hospital	1,731	450	324	117	9
St. Lawrence State Hospital	2,303	392	299	87	6
Utica State Hospital	1,775	402	299	88	15
Willard State Hospital	2,397	558	209	71	278

* Includes other than insane. ** 1919 data. † Data not available.
‡ Includes transfers.

diseases in the United States for the fiscal year 1918—Continued

Total under treatment during year	Discharges								On books at end of fiscal year
	Total	Recovered	Improved	Unimproved	Condition unascertained	No psychosis	Transferred to other hospitals	Died	
8,289	1,840	97	130	8	817	1	258	529	6,449
900	51	.....	.....	.....	21	.....	2	28	849
2,240	456	97	130	8	.....	1	71	149	1,784
1,047	92	.....	.....	.....	44	.....	5	43	955
2,067	673	.....	.....	.....	392	.....	127	154	1,394
1,937	545	.....	.....	.....	340	.....	51	154	1,392
98	23	.....	.....	.....	20	.....	2	1	75
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2,243	622	89	110	79	51	5	.....	288	1,621
6,600	1,416	341	238	88	10	5	.....	734	5,184
1,595	324	70	50	15	10	1	.....	178	1,271
2,275	444	120	66	20	.....	2	.....	236	1,831
1,781	505	127	83	44	.....	.....	.....	251	1,276
949	143	24	39	9	.....	2	.....	69	806
1,681	469	107	146	.....	73	.....	.....	143	1,212
1,681	469	107	146	.....	73	.....	.....	143	1,212
3,115	484	70	69	50	.....	1	3	291	2,631
809	142	33	4	19	.....	1	.....	85	667
1,312	134	23	16	1	.....	.....	3	91	1,178
994	208	14	49	30	.....	.....	.....	115	786
318	82	.....	.....	.....	41	.....	.....	41	236
318	82	.....	.....	.....	41	.....	.....	41	236
1,679	398	64	105	56	13	6	.....	154	1,281
1 679	398	64	105	56	13	6	.....	154	1,281
6,140	1,434	546	195	65	18	4	.....	597	4,706
3,336	667	186	151	10	.....	4	§	316	2,669
2,804	767	360	44	55	18	.....	9	281	2,037
462	141	28	.....	.....	26	.....	.....	87	321
462	141	28	.....	.....	26	.....	.....	87	321
47,544	8,772	1,739	1,775	388	.....	114	845	3,911	38,772
3,184	402	52	71	9	.....	15	23	232	2,782
1,499	597	130	105	21	.....	6	43	292	902
2,739	387	86	75	16	.....	3	6	201	2,352
6,750	1,460	311	336	61	.....	9	225	518	5,290
606	63	35	5	3	.....	2	6	12	543
1,576	265	84	50	16	.....	3	8	104	1,311
4,189	665	134	110	29	.....	25	13	354	3,524
5,784	1,017	205	272	44	.....	18	36	442	4,767
7,604	1,848	317	458	125	.....	8	234	706	5,756
1,015	138	17	26	1	.....	1	52	41	877
2,590	293	59	35	10	.....	8	14	167	2,297
2,181	467	69	77	10	.....	.....	91	220	1,714
2,695	341	97	44	18	.....	8	8	166	2,354
2,177	376	78	72	14	.....	6	69	137	1,801
2,955	453	65	39	11	.....	2	17	319	2,502

§ Transfers included in previous columns.
¶ Term "first admissions" includes patients admitted for first time to this hospital.

Table V—Movement of patient population in state hospitals for mental

HOSPITAL	On books at beginning of fiscal year	Admissions			
		Total	First admissions	Readmissions	Transfers
North Carolina	**3,694**	**750**	.....	.....	.....
State Hospital at Goldsboro	1,010	291	.....	.....	.....
State Hospital (Morganton)	1,530	268	.....	.....	.....
State Hospital (Raleigh)	1,154	191	.....	.....	.....
State Hospital for Dangerous Insane†	.....	.....	.....	.....	.....
North Dakota†	.....	.....	.....	.....	.....
State Hospital for the Insane	.....	.....	.....	.....	.....
Ohio	**12,708**	**3,663**	.....	.....	.....
Athens State Hospital	1,388	262	.....	.....	.....
Cleveland State Hospital	1,979	627	.....	.....	.....
Columbus State Hospital	1,939	620	.....	.....	.....
Dayton State Hospital	1,323	347	.....	.....	.....
Lima State Hospital for the Criminal Insane	771	151	.....	.....	.....
Longview Hospital	1,576	465	.....	.....	.....
Massillon State Hospital	1,832	600	.....	.....	.....
Toledo State Hospital	1,900	591	.....	.....	.....
Oklahoma	.....	.....	.....	.....	.....
East Oklahoma Hospital†	.....	.....	.....	.....	.....
Central Oklahoma State Hospital	1,036	417	.....	.....	.....
Western Oklahoma Hospital	452	134	134	.....	.....
Oregon	**2,110**	**833**	**658**	**150**	**25**
Eastern Oregon State Hospital§	505	139	105	9	25
Oregon State Hospital	1,605	694	553	141	.....
Pennsylvania	**10,348**	**1,841**	**1,477**	**207**	**157**
Homeopathic State Hospital (Allentown)	1,151	306	258	40	8
Pennsylvania State Lunatic Hospital (Harrisburg)	1,415	229	208	21	.....
The State Asylum for the Chronic Insane of Pennsylvania (Wernersville)	929	49	.....	.....	49
State Hospital (Warren)	1,616	359	293	56	10
State Hospital for the Criminal Insane	336	136	46	.....	90
State Hospital for the Insane (Danville)	1,680	358	324	34	‡
State Hospital for the Insane (Norristown)	3,221	404	348	56	.....
Rhode Island	**1,723**	**477**	**377**	**100**	.....
State Hospital for Mental Diseases	1,723	477	377	100	.....
South Carolina	**2,210**	**1,001**	**813**	**188**	.....
State Hospital for the Insane*	2,210	1,001	813	188	.....
South Dakota	**2,110**	**288**	**266**	**22**	.....
Asylum for Insane Indians	67	29	28	1	.....
Yankton State Hospital	1,043	259	238	21	.....
Tennessee	**2,171**	**917**	**485**	**103**	.....
Central State Hospital	778	206	148	58	.....
Eastern State Hospital	644	382	337	45	.....
Western State Hospital	749	329	.....	.....	.....
Texas	**5,850**	**1,398**	.....	.....	.....
North Texas Hospital for the Insane	2,079	292	.....	.....	.....
Southwestern Insane Asylum	1,978	626	.....	.....	.....
State Lunatic Asylum	1,793	480	.....	.....	.....

* Includes other than insane. † Data not available. ‡ Transfers included in

diseases in the United States for the fiscal year 1918—Continued

Total under treatment during year	Discharges								On books at end of fiscal year
	Total	Recovered	Improved	Unimproved	Condition unascertained	No psychosis	Transferred to other hospitals	Died	
4,444	967	207	299	14	4	.....	.....	443	3,477
1,301	308	92	24	9	4	.....	.....	179	993
1,798	309	88	61	5	.....	.....	.....	155	1,489
1,345	350	27	214	.....	.....	.....	.....	109	995
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
16,371	3,493	889	819	140	51	3	88	1,503	12,878
1,650	296	113	40	5	.....	.....	9	129	1,354
2,606	502	134	138	6	.....	.....	37	187	2,104
2,559	580	127	185	31	.....	2	11	224	1,979
1,670	386	129	56	13	.....	.....	4	184	1,284
922	67	25	9	2	.....	.....	4	27	855
2,041	526	92	133	18	51	1	9	222	1,515
2,432	516	172	75	26	.....	.....	13	230	1,916
2,491	620	97	183	39	.....	.....	1	300	1,871
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1,453	539	119	230	20	.....	.....	.....	170	914
586	106	12	45	4	12	3	.....	30	480
2,943	797	124	272	65	95	9	1	231	2,146
644	129	24	35	1	12	1	1	55	515
2,299	668	100	237	64	83	8	.....	176	1,631
12,189	1,871	304	394	122	.....	28	45	978	10,318
1,457	268	66	45	15	.....	16	1	125	1,189
1,644	261	50	28	3	.....	3	14	163	1,383
978	52	.....	.....	6	.....	3	.....	43	926
1,975	406	44	143	20	.....	.....	30	169	1,569
472	30	5	5	.....	.....	2	.....	18	442
2,038	360	59	80	56	.....	4	‡	161	1,678
3,625	494	80	93	22	.....	.....	.....	299	3,131
2,200	461	83	87	60	.....	3	.....	228	1,739
2,200	461	83	87	60	.....	3	.....	228	1,739
3,211	1,023	206	190	59	.....	91	.....	477	2,188
3,211	1,023	206	190	59	.....	91	.....	477	2,188
1,398	240	61	36	9	27	2	.....	105	1,158
96	15	2	3	1	.....	.....	.....	9	81
1,302	225	59	33	8	27	2	.....	96	1,077
3,088	879	92	348	116	.....	11	.....	312	2,209
984	203	5	79	35	.....	4	.....	80	781
1,026	377	22	173	51	.....	.....	.....	131	649
1,078	299	65	96	30	.....	7	.....	101	779
7,248	1,187	291	213	32	129	3	.....	519	6,061
2,371	234	86	16	7	.....	.....	.....	125	2,137
2,604	486	120	100	25	.....	3	.....	238	2,118
2,273	467	85	97	.....	129	.....	.....	156	1,806

previous columns. § Estimated from biennial report.

Table V—Movement of patient population in state hospitals for mental

HOSPITAL	On books at beginning of fiscal year	Admissions			
		Total	First admissions	Re-admissions	Transfers
Utah	632	196	180	16	.....
State Mental Hospital	632	196	180	16	.....
Vermont	669	202	162	40	.....
Vermont State Hospital for the Insane	669	202	162	40	.....
Virginia	5,176	1,480	1,214	247	19
Central State Hospital	1,808	535	451	84	.....
Eastern State Hospital	1,010	260	217	39	4
Southwestern State Hospital	749	286	206	65	15
Western State Hospital	1,609	399	340	59	.....
Washington	3,690	1,099	.....	.....	.....
Eastern State Hospital for the Insane	1,270	241	.....	.....	.....
Northern State Hospital§	843	360	339	19	2
Western State Hospital	1,577	498	488	9	1
West Virginia	1,550	878	598	276	4
Huntington State Hospital*	744	268	208	57	3
Spencer State Hospital§	625	173	114	58	1
Weston State Hospital	1,081	437	276	161	.....
Wisconsin	1,404	1,196	.....	.....	.....
Central State Hospital for the Insane	104	14	14	.....	.....
Northern Hospital for the Insane	624	557	.....	.....	.....
Wisconsin State Hospital for the Insane	676	625	.....	.....	.....
Wyoming	244	71	.....	.....	.....
Wyoming State Hospital for the Insane	244	71	.....	.....	.....

* Includes other than insane. § Estimated from biennial report.

diseases in the United States for the fiscal year 1918—Concluded

Total under treatment during year	Discharges								On books at end of fiscal year
	Total	Recovered	Improved	Unimproved	Condition unascertained	No psychosis	Transferred to other hospitals	Died	
828	**186**	**76**	**55**	**12**	.....	**2**	.....	**41**	**642**
828	186	76	55	12	.....	2	.....	41	642
871	**193**	**36**	**46**	**24**	.....	**3**	.....	**84**	**678**
871	193	36	46	24	.....	3	.....	84	678
6,656	**1,494**	**536**	**200**	**65**	.....	**12**	**4**	**677**	**5,162**
2,343	529	101	105	2	.....	2	.....	319	1,814
1,270	260	97	31	31	.....	1	3	97	1,010
1,035	257	124	47	14	.....	6	1	65	778
2,008	448	214	17	18	.....	3	.....	196	1,560
4,789	**922**	**207**	**328**	**46**	.....	**6**	**4**	**331**	**3,867**
1,511	202	55	29	24	.....	3	.....	91	1,309
1,203	210	71	33	2	.....	3	1	100	993
2,075	510	81	266	20	.....	.....	3	140	1,565
3,328	**866**	**165**	**162**	**52**	**271**	**1**	**5**	**300**	**1,462**
1,012	254	54	74	52	.....	1	2	71	758
798	201	39	.....	.....	86	.....	2	74	597
1,518	411	72	88	.....	185	.....	1	155	1,107
2,600	**1,222**	**5**	.....	.....	**663**	**1**	**398**	**155**	**1,378**
118	16	5	.....	.....	2	.....	7	2	102
1,181	557	.....	.....	.....	281	1	216	59	624
1,301	649	.....	.....	.....	380	.....	175	94	652
315	**51**	**24**	**4**	**3**	**3**	**1**	.....	**16**	**264**
315	51	24	4	3	3	1	.....	16	264

Table VI—Sex distribution of admissions to state hospitals for mental diseases in the United States during the fiscal year 1918

HOSPITAL	TOTAL			FIRST ADMISSIONS			READMISSIONS			TRANSFERS		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
Alabama	454	475	929	.....	.....	.....	.....	.....	.....	.....	.....	.....
Arizona‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Arkansas	697	499	1,196	542	396	938	155	103	258	.....	.....	.....
California	2,028	1,029	3,057	.....	.....	.....	.....	.....	.....	.....	.....	.....
Colorado	244	165	409	239	164	403	5	1	6	.....	.....	.....
Connecticut*	213	240	453	185	202	387	28	38	66	.....	.....	.....
Delaware	69	60	129	58	50	108	11	10	21	.....	.....	.....
District of Columbia	886	168	1,054	.....	.....	.....	.....	.....	.....	.....	.....	.....
Florida	.....	.....	693	.....	.....	.....	.....	.....	.....	.....	.....	.....
Georgia	635	616	1,251	526	509	1,035	109	107	216	.....	.....	.....
Idaho†	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Illinois	3,705	2,484	6,189	2,786	1,885	4,671	578	379	957	341	320	561
Indiana*	409	330	739	148	95	243	18	25	43	.....	.....	.....
Iowa	662	478	1,140	564	380	944	82	89	171	16	9	25
Kansas	402	265	667	.....	.....	.....	.....	.....	.....	.....	.....	.....
Kentucky*	500	393	893	425	333	758	68	58	126	7	2	9
Louisiana	263	180	443	.....	.....	.....	.....	.....	.....	.....	.....	.....
Maine	298	260	558	238	213	451	58	47	105	.....	.....	.....
Maryland*	339	258	597	203	168	371	58	42	100	78	48	126
Massachusetts	2,928	2,756	5,684	1,935	1,745	3,680	834	712	1,546	159	299	458
Michigan	1,399	1,083	2,482	.....	.....	.....	.....	.....	.....	.....	.....	.....
Minnesota	1,301	735	2,036	786	530	1,316	258	164	422	257	41	298
Mississippi*	325	294	619	.....	.....	.....	.....	.....	.....	.....	.....	.....

* Data incomplete; see Table No. 5. † 1919 data. ‡ Data not available.

Table VI—Sex distribution of admissions to state hospitals for mental diseases in the United States during the fiscal year 1918—Concluded

HOSPITAL	Total			First Admissions			Readmissions			Transfers		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
Missouri	741	563	1,304	.....	.....	.....	.....	.....	.....	.....	.....	.....
Montana	436	154	590	.....	.....	.....	.....	.....	.....	.....	.....	.....
Nebraska	322	235	557	258	178	436	64	57	121	.....	.....	.....
Nevada	52	14	66	.....	.....	.....	.....	.....	.....	.....	.....	.....
New Hampshire	236	210	446	.....	.....	.....	.....	.....	.....	.....	.....	.....
New Jersey†	691	658	1,349	595	559	1,154	96	99	195	.....	.....	.....
New Mexico	82	52	134	.....	.....	.....	.....	.....	.....	.....	.....	.....
New York	5,017	4,737	9,754	3,668	3,288	6,956	893	1,034	1,927	456	415	871
North Carolina	.....	.....	750	.....	.....	.....	.....	.....	.....	.....	.....	.....
North Dakota‡	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Ohio	2,186	1,477	3,663	.....	.....	.....	.....	.....	.....	.....	.....	.....
Oklahoma*	320	231	551	.....	.....	.....	.....	.....	.....	.....	.....	.....
Oregon	523	310	833	416	242	658	90	60	150	17	8	25
Pennsylvania	1,105	736	1,841	852	625	1,477	118	89	207	135	22	157
Rhode Island	279	198	477	219	158	377	60	40	100	.....	.....	.....
South Carolina	524	477	1,001	427	386	813	97	91	188	.....	.....	.....
South Dakota	161	98	259	143	95	238	18	3	21	.....	.....	.....
Tennessee	455	462	917	.....	.....	.....	.....	.....	.....	.....	.....	.....
Texas	768	630	1,398	.....	.....	.....	.....	.....	.....	.....	.....	.....
Utah	110	86	196	102	78	180	8	8	16	.....	.....	.....
Vermont	112	90	202	86	76	162	26	14	40	.....	.....	.....
Virginia	783	697	1,480	636	578	1,214	138	109	247	9	10	19
Washington	737	362	1,099	.....	.....	.....	.....	.....	.....	.....	.....	.....
West Virginia	483	395	878	331	267	598	149	127	276	1	.....	1
Wisconsin	716	480	1,196	.....	.....	.....	.....	.....	.....	.....	.....	.....
Wyoming	.....	.....	71	.....	.....	.....	.....	.....	.....	.....	.....	.....

* Data incomplete; see Table No. 5. † 1919 data. ‡ Data not available.

Table VII—Patients discharged as recovered and improved from state hospitals for mental diseases in the United States during the fiscal year 1918

(Hospitals for which no data were obtained are omitted.)

HOSPITAL	Recovered				Improved			
	Males	Females	Total	Per cent of admissions*	Males	Females	Total	Per cent of admissions*
Arkansas	**26**	**10**	**36**	**3.0**	**6**	**3**	**9**	**0.8**
State Hospital for Nervous Diseases	26	10	36	3.0	6	3	9	0.8
California	**420**	**283**	**703**	**23.0**	**334**	**129**	**463**	**15.1**
Agnews State Hospital	59	72	131	25.5	53	22	75	14.6
Mendocino State Hospital	29	12	41	19.9	9	4	13	6.3
Napa State Hospital	23	10	33	5.1	119	43	162	25.0
Norwalk State Hospital	10	....	10	13.9	14	....	14	19.4
Southern California State Hospital	148	117	265	30.7	82	44	126	14.6
Stockton State Hospital	151	72	223	29.5	57	16	73	9.7
Colorado	**30**	**23**	**53**	**13.0**	**38**	**24**	**62**	**15.2**
Colorado State Hospital	30	23	53	13.0	38	24	62	15.2
Connecticut	....	....	....	.....	....	....	....	.....
Connecticut State Hospital	53	31	84	18.4	53	53	106	23.2
Delaware	**17**	**11**	**28**	**21.7**	**6**	**8**	**14**	**10.9**
Delaware State Hospital at Farnhurst	17	11	28	21.7	6	8	14	10.9
District of Columbia	**235**	**46**	**281**	**26.7**	**113**	**18**	**131**	**12.4**
St. Elizabeths Hospital	235	46	281	26.7	113	18	131	12.4
Florida	**77**	**21**	**98**	**14.1**	**87**	**25**	**112**	**16.2**
Florida Hospital for the Insane	77	21	98	14.1	87	25	112	16.2
Georgia	**107**	**39**	**146**	**11.7**	**120**	**222**	**342**	**27.3**
Georgia State Sanitarium	107	39	146	11.7	120	222	342	27.3
Illinois†	**329**	**232**	**561**	**10.0**	**1,494**	**848**	**2,342**	**41.9**
Alton State Hospital	3	1	4	2.2	88	45	133	74.3
Anna State Hospital	23	20	43	7.1	127	92	219	36.1
Chicago State Hospital	80	60	140	8.1	588	282	870	50.4
Elgin State Hospital	68	53	121	13.8	120	123	243	27.6
Jacksonville State Hospital	41	29	70	15.1	107	67	174	37.6
Kankakee State Hospital	44	35	79	8.6	188	100	288	31.4
Peoria State Hospital	10	10	20	4.9	140	79	219	53.4
Watertown State Hospital	60	24	84	20.3	136	60	196	47.3
Indiana	....	....	....	.....	....	....	....	.....
Central Indiana Hospital for the Insane	22	29	51	44.3	45	18	63	54.8
Eastern Indiana Hospital for the Insane	15	12	27	27.6	13	9	22	22.4
Indiana Hospital for Insane Criminals	11	....	11	55.0	....	....	....	.....
Northern Hospital for the Insane	32	12	44	18.3	100	66	166	69.2
Southeastern Hospital for the Insane	12	15	27	10.2	32	40	72	27.1

* Excluding transfers wherever ascertained; see Table No. 5.

† Not including hospital for criminal insane.

Table VII—Patients discharged as recovered and improved from state hospitals for mental diseases in the United States during the fiscal year 1918—Continued

HOSPITAL	Recovered				Improved			
	Males	Females	Total	Per cent of admissions*	Males	Females	Total	Per cent of admissions*
Iowa§	**85**	**82**	**167**	**15.0**	**11**	**9**	**20**	**1.8**
Cherokee State Hospital	17	11	28	9.7	1	....	1	0.3
Clarinda State Hospital	39	25	64	20.6	10	9	19	6.1
Independence State Hospital	21	30	51	17.9	....	....	....	.....
Mount Pleasant State Hospital	8	16	24	10.4	....	....	....	.....
Kansas	....	....	....	.....	....	....	....	.....
Hospital for the Dangerous Insane	5	....	5	17.2	....	....	....	.....
Osawatomie State Hospital	29	47	76	29.9	73	90	163	64.2
Topeka State Hospital	34	23	57	15.3	36	22	58	15.5
Kentucky	....	....	....	.....	....	....	....	.....
Central State Hospital	23	37	60	13.4	93	78	171	38.1
Eastern State Hospital	7	38	45	10.3	116	59	175	40.2
Louisiana	....	....	....	.....	....	....	....	.....
East Louisiana Hospital for the Insane**	13	13	26	11.9	34	17	51	23.4
Maine	**29**	**18**	**47**	**8.5**	**32**	**26**	**58**	**10.4**
Augusta State Hospital	26	18	44	15.0	26	22	48	16.3
Bangor State Hospital	3	....	3	1.1	6	4	10	3.8
Maryland	....	....	....	.....	....	....	....	.....
Eastern Shore State Hospital	5	3	8	11.6	16	12	28	40.6
Spring Grove State Hospital	25	18	43	32.3	17	7	24	18.0
Springfield State Hospital†	43	40	83	30.9	49	51	100	37.2
Massachusetts	**216**	**122**	**338**	**6.5**	**502**	**402**	**904**	**17.3**
Boston State Hospital	37	28	65	3.0	221	151	372	17.0
Bridgewater State Hospital	14	....	14	22.6	1	....	1	1.6
Danvers State Hospital	31	10	41	5.7	87	84	171	23.8
Foxborough State Hospital	3	....	3	6.4	3	6	9	19.1
Gardner State Colony	....	....	....	.....	11	1	12	‡
Grafton State Hospital	....	....	....	.....	22	4	26	44.1
Medfield State Hospital	4	6	10	7.2	11	8	19	13.7
Northampton State Hospital	43	21	64	15.8	37	26	63	15.6
State Infirmary	....	....	....	.....	1	3	4	13.3
Taunton State Hospital	32	11	43	9 0	40	31	71	14.8
Westborough State Hospital	19	23	42	8.8	41	49	90	18.9
Worcester State Hospital	33	23	56	8.9	27	39	66	10.5
Michigan	**128**	**112**	**240**	**10.6**	**305**	**193**	**498**	**22.0**
Ionia State Hospital	19	....	19	37.3	6	....	6	11.8
Kalamazoo State Hospital	31	22	53	5.7	107	70	177	19.0
Newberry State Hospital	20	17	37	13.3	62	28	90	32.4

* Excluding transfers wherever ascertained; see Table No. 5.
** Estimated from biennial report.
† 1919 data.
§ Not including hospital for criminal insane.
‡ All admissions are by transfer.

Table VII—Patients discharged as recovered and improved from state hospitals for mental diseases in the United States during the fiscal year 1918—Continued

HOSPITAL	Recovered				Improved			
	Males	Females	Total	Per cent of admissions*	Males	Females	Total	Per cent of admissions*
Michigan—Concluded								
Pontiac State Hospital	32	30	62	15.6	56	30	86	21.6
State Psychopathic Hospital	11	20	31	13.5	33	37	70	30.4
Traverse City State Hospital	15	23	38	10.2	41	28	69	18.4
Minnesota	....	....	....	.....	....	....	....	.....
Fergus Falls State Hospital	56	41	97	19.3	77	53	130	25.9
Mississippi	....	....	....	.....	....	....	....	.....
Mississippi State Insane Hospital	46	43	89	14.4	48	62	110	17.8
Missouri	**162**	**179**	**341**	**26.2**	**120**	**118**	**238**	**18.3**
State Hospital No. 1	43	27	70	22.2	20	30	50	15.9
State Hospital No. 2	61	59	120	28.8	32	34	66	15.8
State Hospital No. 3	51	76	127	33.4	52	31	83	21.8
State Hospital No. 4	7	17	24	12.5	16	23	39	20.3
Montana	**84**	**23**	**107**	**18.1**	**94**	**52**	**146**	**24.7**
Montana State Hospital for the Insane	84	23	107	18.1	94	52	146	24.7
Nebraska	**25**	**45**	**70**	**12.6**	**30**	**39**	**69**	**12.4**
Hospital for the Insane of Nebraska (Norfolk)	16	17	33	21.3	2	2	4	2.6
Ingleside Hospital for the Insane	3	20	23	13.6	2	14	16	9.5
Nebraska Hospital for the Insane (Lincoln)	6	8	14	6.0	26	23	49	21.0
New Hampshire	**39**	**25**	**64**	**14.3**	**57**	**48**	**105**	**23.5**
New Hampshire State Hospital	39	25	64	14.3	57	48	105	23.5
New Jersey†	**274**	**272**	**546**	**40.5**	**98**	**97**	**195**	**14.5**
The New Jersey State Hospital at Morris Plains	89	97	186	30.3	72	79	151	24.6
The New Jersey State Hospital at Trenton	185	175	360	48.9	26	18	44	6.0
New Mexico	**16**	**12**	**28**	**20.9**	....	....	....	.....
State Hospital	12	12	28	20.9	....	....	....	.....
New York	**849**	**890**	**1,739**	**19.4**	**879**	**896**	**1,775**	**20.0**
Binghamton State Hospital	28	24	52	18.3	41	30	71	25.0
Brooklyn State Hospital	42	88	130	22.0	42	63	105	17.8
Buffalo State Hospital	32	54	86	18.7	36	39	75	16.3
Central Islip State Hospital	128	183	311	20.3	183	153	336	21.9
Dannemora State Hospital	35	....	35	58.3	5	....	5	8.3
Gowanda State Homeopathic Hospital	52	32	84	32.2	36	14	50	19.2
Hudson River State Hospital	63	71	134	20.2	54	56	110	16.6

* Excluding transfers wherever ascertained; see Table No. 5.
† 1919 data.

Table VII—Patients discharged as recovered and improved from state hospitals for mental diseases in the United States during the fiscal year 1918—Continued

HOSPITAL	Recovered				Improved			
	Males	Females	Total	Per cent of admissions*	Males	Females	Total	Per cent of admissions*
New York—Concluded								
Kings Park State Hospital	99	106	205	19.6	142	130	272	26.0
Manhattan State Hospital	174	143	317	15.1	197	261	458	21.7
Matteawan State Hospital	15	2	17	13.8	17	9	26	21.1
Middletown State Homeopathic Hospital	33	26	59	22.6	14	21	35	13.4
Rochester State Hospital	34	35	69	15.6	29	48	77	17.5
St. Lawrence State Hospital	51	46	97	25.1	19	25	44	11.4
Utica State Hospital	33	45	78	20.2	44	28	72	18.6
Willard State Hospital	30	35	65	23.2	20	19	39	13.9
North Carolina‡	....	....	207	27.6	....	....	109	14.5
State Hospital at Goldsboro	38	54	92	31.6	8	16	24	8.2
State Hospital (Morganton)	46	42	88	32.8	21	40	61	22.8
State Hospital (Raleigh)	....	....	27	14.1	....	....	214	112.0
Ohio	548	341	889	24.6	484	335	819	22.7
Athens State Hospital	66	47	113	43.1	22	18	40	15.3
Cleveland State Hospital	90	44	134	21.4	82	56	138	22.0
Columbus State Hospital	59	68	127	20.5	122	63	185	29.8
Dayton State Hospital	75	54	129	37.2	29	27	56	16.1
Lima State Hospital for the Criminal Insane	19	6	25	24.5	9	....	9	8.8
Longview Hospital	67	25	92	19.8	76	57	133	28.6
Massillon State Hospital	114	58	172	28.7	38	37	75	12.5
Toledo State Hospital	58	39	97	16.4	106	77	183	31.0
Oklahoma	....	....	....	.....	....	....	....	.....
Central Oklahoma State Hospital	60	59	119	28.3	133	97	230	55.2
Western Oklahoma Hospital	7	5	12	9.0	29	16	45	33.6
Oregon	70	54	124	15.3	136	136	272	33.7
Eastern Oregon State Hospital†	16	8	24	21.1	24	11	35	30.7
Oregon State Hospital	54	46	100	14.4	112	125	237	34.1
Pennsylvania	140	164	304	18.1	262	132	394	23.4
Homeopathic State Hospital (Allentown)	36	30	66	22.1	25	20	45	15.1
Pennsylvania State Lunatic Hospital (Harrisburg)	23	27	50	21.8	13	15	28	12.2
The State Asylum for the Chronic Insane of Pennsylvania (Wernersville)	None	None	None	.....	None	None	None	.....
State Hospital (Warren)	16	28	44	12.6	106	37	143	41.0
State Hospital for the Criminal Insane	5	....	5	10.9	5	....	5	10.9

* Excluding transfers wherever ascertained; see Table No. 5.
† Estimated from biennial report.
‡ Not including hospital for the criminal insane.

Table VII—Patients discharged as recovered and improved from state hospitals for mental diseases in the United States during the fiscal year 1918—Concluded

HOSPITAL	Recovered				Improved			
	Males	Females	Total	Per cent of admissions*	Males	Females	Total	Per cent of admissions*
Pennsylvania—Concluded								
State Hospital for the Insane (Danville)	30	29	59	16.5	51	29	80	22.3
State Hospital for the Insane (Norristown)	30	50	80	19.8	62	31	93	23.0
Rhode Island	**55**	**28**	**83**	**17.4**	**45**	**42**	**87**	**18.2**
State Hospital for Mental Diseases	55	28	83	17.4	45	42	87	18.2
South Carolina	**101**	**105**	**206**	**20.6**	**94**	**96**	**190**	**19.0**
State Hospital for the Insane	101	105	206	20.6	94	96	190	19.0
South Dakota	....	....	....	.....	....	....	....	.....
Asylum for Insane Indians	2	....	2	6.9	2	1	3	10.3
Yankton State Hospital	41	18	59	22.8	20	13	33	12.7
Tennessee	**43**	**49**	**92**	**10.0**	**177**	**171**	**348**	**37.9**
Central State Hospital	4	1	5	2.4	44	35	79	38.3
Eastern State Hospital	3	19	22	5.8	85	88	173	45.3
Western State Hospital†	36	29	65	19.8	48	48	96	29.2
Texas	**147**	**144**	**291**	**20.8**	**114**	**99**	**213**	**15.2**
North Texas Hospital for the Insane	32	54	86	29.5	5	11	16	5.5
Southwestern Insane Asylum	66	54	120	19.2	51	49	100	16.0
State Lunatic Asylum	49	36	85	17.7	58	39	97	20.2
Utah	**42**	**34**	**76**	**38.8**	**25**	**30**	**55**	**28.1**
State Mental Hospital	42	34	76	38.8	25	30	55	28.1
Vermont	**22**	**14**	**36**	**17.8**	**30**	**16**	**46**	**22.8**
Vermont State Hospital for the Insane	22	14	36	17.8	30	16	46	22.8
Virginia	**314**	**222**	**536**	**36.7**	**110**	**90**	**200**	**13.7**
Central State Hospital	44	57	101	18.9	56	49	105	19.6
Eastern State Hospital	81	16	97	37.9	21	10	31	12.1
Southwestern State Hospital	79	45	124	45.8	24	23	47	17.3
Western State Hospital	110	104	214	53.6	9	8	17	4.3
Washington	**120**	**87**	**207**	**18.9**	**270**	**58**	**328**	**29.9**
Eastern State Hospital	31	24	55	22.8	22	7	29	12.0
Northern State Hospital†	52	19	71	19.8	24	9	33	9.2
Western State Hospital	37	44	81	16.3	224	42	266	53.5
West Virginia	**93**	**72**	**165**	**18.9**	**79**	**83**	**162**	**18.5**
Huntington State Hospital	26	28	54	20.1	41	33	74	27.6
Spencer State Hospital†	29	10	39	22.7	....	....	....	.....
Weston State Hospital	38	34	72	16.5	38	50	88	20.1
Wisconsin	....	....	....	.....	....	....	....	.....
Central State Hospital for the Insane	5	....	5	35.7	....	....	....	.....
Wyoming	....	....	....	.....	....	....	....	.....
Wyoming State Hospital for the Insane	....	....	24	33.8	....	....	4	5.6

* Excluding transfers wherever ascertained; see Table No. 5.
† Estimated from biennial report.

Table VIII—Deaths of patients in state hospitals for mental diseases in the United States during the fiscal year 1918

(Hospitals for which no data were obtained are omitted.)

HOSPITAL	Number			Rate Per 1,000 of Average Daily Population			Rate Per 1,000 of Patients Under Treatment		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Alabama	**268**	**267**	**535**	....	....	....	....	....	**146.4**
The Bryce Hospital	182	168	350	....	....	....	....	....	137.9
The Mt. Vernon Hospital	86	99	185	....	....	....	....	....	165.6
Arkansas	**247**	**143**	**390**	**239.6**	**145.9**	**193.9**	**143.1**	**96.1**	**121.3**
State Hospital for Nervous Diseases	247	143	390	239.6	145.9	193.9	143.1	96.1	121.3
California	**700**	**349**	**1,049**	....	....	**103.0**	**86.1**	**66.8**	**78.6**
Agnews State Hospital	129	86	215	....	....	131.3	109.0	89.7	100.4
Mendocino State Hospital	61	21	82	74.1	63.3	71.0	65.0	55.7	62.4
Napa State Hospital	121	74	195	96.5	69.2	83.9	65.8	56.8	62.1
Norwalk State Hospital	24	....	24	98.0	....	98.0	77.7	....	77.7
Southern California State Hospital	173	97	270	....	....	113.4	94.5	69.0	83.4
Stockton State Hospital	192	71	263	....	....	107.6	94.7	60.2	82.0
Colorado	**119**	**74**	**193**	**127.4**	**103.9**	**117.3**	**100.3**	**85.0**	**93.8**
Colorado State Hospital	119	74	193	127.4	103.9	117.3	100.3	85.0	93.8
Connecticut	....	....	474	....	....	123.2	....	....	97.5
Connecticut State Hospital	134	143	277	105.0	106.7	105.9	88.2	89.6	88.9
Norwich State Hospital for the Insane	....	....	197	....	....	160.0	....	....	112.9
Delaware	**44**	**28**	**72**	**158.8**	**119.7**	**140.9**	**127.2**	**97.6**	**113.7**
Delaware State Hospital at Farnhurst	44	28	72	158.8	119.7	140.9	127.2	97.6	113.7
District of Columbia	**247**	**86**	**333**	**99.8**	**100.6**	**100.0**	**75.6**	**83.3**	**77.5**
St. Elizabeths Hospital	247	86	333	99.8	100.6	100.0	75.6	83.3	77.5
Florida	**286**	**189**	**475**	....	....	**306.3**	....	....	**208.9**
Florida Hospital for the Insane	286	189	475	....	....	306.3	....	....	208.9
Georgia	**383**	**313**	**696**	....	....	**170.7**	....	....	**130.8**
Georgia State Sanitarium	383	313	696	....	....	170.7	....	....	130.8
Illinois	**1,508**	**907**	**2,415**	**162.9**	**113.0**	**139.7**	**109.0**	**83.3**	**97.7**
Alton State Hospital	60	73	133	196.7	228.8	213.1	118.6	159.7	138.1
Anna State Hospital	134	73	207	140.0	90.5	117.3	96.1	65.1	82.3
Chester State Hospital	5	....	5	26.2	....	26.2	19.7	....	19.7
Chicago State Hospital	408	243	651	219.7	170.5	198.4	128.3	108.7	120.2
Elgin State Hospital	185	106	291	187.4	98.3	140.9	114.3	67.4	91.2
Jacksonville State Hospital	142	69	211	130.3	68.8	100.8	93.8	54.9	76.2
Kankakee State Hospital	242	168	410	139.2	110.5	125.8	100.5	85.6	93.8
Peoria State Hospital	179	101	280	150.0	89.3	120.5	109.4	74.6	93.6
Watertown State Hospital	153	74	227	162.9	99.3	134.8	115.7	79.5	100.8
Indiana	....	....	....	....	....	....	....	....	.....
Central Indiana Hospital for the Insane	71	69	140	103.2	84.8	93.2	86.6	74.2	80.0
Eastern Indiana Hospital for the Insane	39	15	54	89.7	34.4	62.0	74.9	31.0	53.7
Indiana Hospital for Insane Criminals	5	....	5	28.1	....	28.1	25.5	....	25.5

Table VIII—Deaths of patients in state hospitals for mental diseases in the United States during the fiscal year 1918—Continued

HOSPITAL	Number			Rate Per 1,000 of Average Daily Population			Rate Per 1,000 of Patients Under Treatment		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Indiana—Concluded									
Northern Hospital for the Insane	72	52	124	145.5	112.1	129.3	92.9	80.0	87.0
Southeastern Hospital for the Insane	71	67	138	115.8	121.2	118.4	91.8	93.2	92.5
Iowa	**301**	**189**	**490**	**116.9**	**94.4**	**107.1**	**84.4**	**70.2**	**78.3**
Cherokee State Hospital	69	48	117	110.2	98.6	105.1	77.5	74.2	76.1
Clarinda State Hospital	88	60	148	127.5	118.8	123.8	91.4	81.7	87.2
Independence State Hospital	81	42	123	125.4	83.7	107.1	83.8	59.0	73.3
Mount Pleasant State Hospital	63	39	102	102.9	76.8	91.1	84.6	64.9	75.8
Kansas	**253**	**122**	**375**	**149.0**	**89.1**	**122.3**	**108.4**	**68.7**	**91.3**
Hospital for the Dangerous Insane	None	None	None	None	None	None	None	None	None
Larned State Hospital	1	1	2	10.9	50.0	17.9	9.8	45.5	16.1
Osawatomie State Hospital	91	67	158	141.7	95.3	117.5	93.9	69.5	81.7
Topeka State Hospital	161	54	215	177.1	83.6	138.3	135.1	68.4	108.5
Kentucky	....	....	....	....	....	....	....	....	.....
Central State Hospital	127	95	222	....	....	....	102.4	94.7	99.0
Eastern State Hospital	144	96	240	189.0	164.1	178.3	133.1	120.0	127.5
Louisiana*	**86**	**50**	**136**	....	....	**52.8**	....	....	**45.7**
East Louisiana Hospital for the Insane	59	29	88	....	....	52.4	58.5	33.8	47.2
Louisiana Hospital for the Insane	27	21	48	....	....	53.3	....	....	43.3
Maine	**137**	**98**	**235**	**151.9**	**117.6**	**135.4**	**113.9**	**91.1**	**103.1**
Augusta State Hospital	67	62	129	124.1	125.5	124.8	92.3	94.4	93.3
Bangor State Hospital	70	36	106	193.4	106.2	151.2	146.8	85.9	118.3
Maryland	....	....	....	....	....	....	....	....	.....
Eastern Shore State Hospital	21	19	40	152.2	186.3	166.7	114.1	136.7	123.8
Spring Grove State Hospital	48	40	88	120.6	101.5	111.1	95.0	87.3	91.4
Springfield State Hospital‡	119	58	177	....	....	....	118.4	67.1	94.7
Massachusetts	**973**	**742**	**1,715**	**134.9**	**102.6**	**118.7**	**89.8**	**69.1**	**79.5**
Boston State Hospital	178	124	302	245.2	142.2	189.1	89.5	61.9	75.6
Bridgewater State Hospital	73	....	73	86.1	....	86.1	79.5	....	79.5
Danvers State Hospital	131	99	230	205.3	114.6	153.1	115.5	73.0	92.4
Foxborough State Hospital	19	17	36	93.1	92.9	93.0	68.8	65.6	67.3
Gardner State Colony	11	5	16	22.3	16.6	20.1	20.3	14.5	18.0
Grafton State Hospital	97	77	174	104.9	78.8	91.5	88.7	70.3	79.5
Medfield State Hospital	61	60	121	91.5	61.4	73.6	81.4	55.6	66.2
Northampton State Hospital	77	69	146	156.8	141.4	149.1	100.4	91.3	95.9
State Infirmary	20	42	62	100.0	80.6	86.1	84.4	71.3	75.1
Taunton State Hospital	110	77	187	164.2	115.8	140.1	109.2	76.5	92.9
Westborough State Hospital	87	72	159	166.0	105.6	131.8	104.8	63.5	81.0
Worcester State Hospital	109	100	209	131.8	142.2	136.6	84.4	89.9	86.9

* Estimated from biennial report. ‡ 1919 data.

Table VIII—Deaths of patients in state hospitals for mental diseases in the United States during the fiscal year 1918—Continued

HOSPITAL	Number			Rate Per 1,000 of Average Daily Population			Rate Per 1,000 of Patients Under Treatment		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Michigan	478	350	828	....	....	117.8	90.6	83.4	87.4
Ionia State Hospital	16	1	17	37.3	15.4	34.5	33.6	14.9	31.3
Kalamazoo State Hospital	161	137	298	144.1	125.1	134.7	96.8	90.9	94.0
Newberry State Hospital	55	31	86	....	....	84.7	75.5	55.9	67.0
Pontiac State Hospital	122	91	213	....	....	144.5	113.7	104.7	109.7
State Psychopathic Hospital	5	7	12	204.8	217.7	212.1	41.7	41.9	41.8
Traverse City State Hospital	119	83	202	126.7	88.2	113.5	98.1	80.3	89.9
Minnesota	328	201	529	91.0	77.2	85.2	66.5	59.8	63.8
Anoka State Asylum	16	12	28	54.6	20.9	32.3	52.1	20.2	31.1
Fergus Falls State Hospital	97	52	149	107.3	73.3	92.4	74.5	55.4	66.5
Hastings State Asylum	43	....	43	45.5	....	45.5	41.1	....	41.1
Rochester State Hospital	87	67	154	131.8	92.7	111.4	79.9	68.5	74.5
St. Peter State Hospital	84	70	154	114.3	117.1	115.5	77.3	82.4	79.5
Willmar State Asylum	1	....	1	15.2	....	15.2	10.2	....	10.2
Mississippi	....	....	....	....	....	....	....	....	.....
Mississippi State Insane Hospital	150	138	288	....	....	177.6	134.6	122.2	128.4
Missouri	466	268	734	....	....	146.0	129.1	89.7	111.2
State Hospital No. 1	103	75	178	134.8	146.8	139.6	108.2	116.6	111.6
State Hospital No. 2	144	92	236	....	....	135.1	116.6	88.5	103.7
State Hospital No. 3	180	71	251	....	....	199.8	187.9	86.3	140.9
State Hospital No. 4	39	30	69	105.1	79.2	92.0	83.7	62.1	72.7
Montana	97	46	143	118.1	139.4	124.2	80.0	98.3	85.1
Montana State Hospital for the Insane	97	46	143	118.1	139.4	124.2	80.0	98.3	85.1
Nebraska	180	111	291	124.7	99.7	113.8	102.4	81.8	93.4
Hospital for the Insane of Nebraska (Norfolk)	54	31	85	153.4	113.1	135.8	117.1	89.1	105.1
Ingleside Hospital for the Insane	60	31	91	80.8	74.5	78.5	72.0	64.7	69.4
Nebraska Hospital for the Insane (Lincoln)	66	49	115	189.7	115.8	149.2	142.2	92.5	115.7
Nevada	35	6	41	203.2	85.0	168.8	150.2	70.6	128.9
Nevada Hospital for Mental Diseases	35	6	41	203.2	85.0	168.8	150.2	70.6	128.9
New Hampshire	74	80	154	118.2	127.4	122.8	87.2	96.4	91.7
New Hampshire State Hospital	74	80	154	118.2	127.4	122.8	87.2	96.4	91.7
New Jersey‡	301	296	597	131.5	132.0	131.8	96.4	98.1	97.2
The New Jersey State Hospital at Morris Plains	132	184	316	104.1	131.8	118.7	83.2	105.1	94.7
The New Jersey State Hospital at Trenton	169	112	281	165.5	132.4	150.5	110.0	88.3	100.2
New Mexico	56	31	87	....	....	255.9	209.0	159.8	188.3
State Hospital	56	31	87	....	....	255.9	209.0	159.8	188.3

‡ 1919 data.

Table VIII—Deaths of patients in state hospitals for mental diseases in the United States during the fiscal year 1918—Continued

HOSPITAL	Number			Rate Per 1,000 of Average Daily Population			Rate Per 1,000 of Patients Under Treatment		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
New York	**2,146**	**1,765**	**3,911**	**122.5**	**93.0**	**107.2**	**92.9**	**72.2**	**82.3**
Binghamton State Hospital	121	111	232	80.1	92.4	85.5	69.5	76.9	72.9
Brooklyn State Hospital	153	139	292	369.6	309.6	338.4	218.3	174.2	194.8
Buffalo State Hospital	114	87	201	113.9	72.9	91.6	90.2	59.0	73.4
Central Islip State Hospital	332	186	518	121.0	84.2	104.6	91.3	59.7	76.7
Dannemora State Hospital	12	....	12	21.8	....	21.8	19.8	....	19.8
Gowanda State Homeopathic Hospital	75	29	104	105.5	50.6	81.0	83.6	42.7	66.0
Hudson River State Hospital	165	189	354	108.8	98.7	103.1	87.7	81.9	84.5
Kings Park State Hospital	252	190	442	137.9	72.9	99.6	100.0	58.2	76.4
Manhattan State Hospital	349	357	706	168.3	118.6	138.9	104.9	83.5	92.8
Matteawan State Hospital	31	10	41	41.0	66.2	45.2	36.7	58.8	40.4
Middletown State Homeopathic Hospital	90	77	167	112.6	54.8	75.8	91.6	47.9	64.5
Rochester State Hospital	100	120	220	161.3	123.3	138.1	112.1	93.1	100.9
St. Lawrence State Hospital	92	74	166	89.8	59.9	73.5	72.7	51.7	61.6
Utica State Hospital	75	62	137	89.6	73.0	81.3	69.1	56.8	62.9
Willard State Hospital	185	134	319	164.3	109.9	136.0	126.6	89.7	108.0
North Carolina	....	....	**443**	....	....	**134.6**	....	....	**99.7**
State Hospital at Goldsboro	80	99	179	....	....	187.6	156.9	125.2	137.6
State Hospital (Morganton)	73	82	155	....	....	116.5	95.2	79.5	86.2
State Hospital (Raleigh)	....	....	109	....	....	108.2	....	....	81.0
Ohio	**897**	**606**	**1,503**	**138.2**	**106.1**	**123.2**	**100.1**	**81.7**	**91.8**
Athens State Hospital	76	53	129	112.9	78.4	95.6	89.5	66.2	78.2
Cleveland State Hospital	118	69	187	130.1	82.3	107.2	82.0	59.1	71.8
Columbus State Hospital	141	83	224	144.8	95.3	121.4	102.0	70.5	87.5
Dayton State Hospital	99	85	184	156.4	138.9	147.8	113.8	106.3	110.2
Lima State Hospital for the Criminal Insane	19	8	27	28.8	51.0	33.1	25.2	47.3	29.3
Longview Hospital	129	93	222	168.8	116.7	142.2	123.0	93.8	108.8
Massillon State Hospital	134	96	230	135.2	113.6	125.3	98.4	89.7	94.6
Toledo State Hospital	181	119	300	203.4	129.9	166.1	144.3	96.2	120.4
Oklahoma	....	....	....	....	....	....	....	....	.....
Central Oklahoma State Hospital	127	43	170	....	....	169.3	151.9	69.7	117.0
Western Oklahoma Hospital	15	15	30	47.8	90.4	62.5	39.6	72.5	51.2
Oregon	**152**	**79**	**231**	....	....	**108.2**	**80.6**	**74.7**	**78.5**
Eastern Oregon State Hospital	39	16	55	....	....	112.7	87.4	80.8	85.4
Oregon State Hospital	113	63	176	108.3	104.5	106.9	78.5	73.3	76.6
Pennsylvania	**576**	**402**	**978**	**107.3**	**90.1**	**99.5**	**85.0**	**74.2**	**80.2**
Homeopathic State Hospital (Allentown)	68	57	125	124.8	102.2	113.3	93.7	78.0	85.8
Pennsylvania State Lunatic Hospital (Harrisburg)	100	63	163	168.1	102.3	134.6	118.6	78.7	99.1
The State Asylum for the Chronic Insane of Pennsylvania (Wernersville)	32	11	43	44.9	52.1	46.5	42.2	50.0	44.0
State Hospital (Warren)	103	66	169	132.9	88.7	111.3	96.4	72.8	85.6
State Hospital for the Criminal Insane	18	....	18	45.6	....	45.6	38.1	....	38.1

Table VIII—Deaths of patients in state hospitals for mental diseases in the United States during the fiscal year 1918—Continued

HOSPITAL	Number			Rate Per 1,000 of Average Daily Population			Rate Per 1,000 of Patients Under Treatment		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Pennsylvania—Concluded									
State Hospital for the Insane (Danville)	93	68	161	102.6	87.2	95.5	82.7	74.5	79.0
State Hospital for the Insane (Norristown)	162	137	299	112.6	88.2	99.9	91.0	74.3	82.5
Rhode Island	**125**	**103**	**228**	**171.5**	**150.8**	**161.4**	**104.3**	**102.8**	**103.6**
State Hospital for Mental Diseases	125	103	228	171.5	150.8	161.4	104.3	102.8	103.6
South Carolina	**243**	**234**	**477**	**234.6**	**224.8**	**229.7**	**149.8**	**147.3**	**148.6**
State Hospital for the Insane	243	234	477	234.6	224.8	229.7	149.8	147.3	148.6
South Dakota	....	....	....	....	....	....	....	....	....
Asylum for Insane Indians	6	3	9	140.3	86.4	116.1	111.1	71.4	93.8
Yankton State Hospital	73	23	96	113.9	55.0	90.7	91.0	46.0	73.7
Tennessee	**155**	**157**	**312**	**150.9**	**135.7**	**142.9**	**105.2**	**97.3**	**101.0**
Central State Hospital	48	32	80	128.3	78.8	102.6	98.8	64.3	81.3
Eastern State Hospital	57	74	131	199.3	205.0	202.5	122.8	131.7	127.7
Western State Hospital	50	51	101	136.2	130.8	133.4	95.4	92.1	93.7
Texas	**308**	**211**	**519**	....	....	**91.8**	**84.3**	**58.7**	**71.6**
North Texas Hospital for the Insane	76	49	125	78.8	52.0	65.5	63.5	41.7	52.7
Southwestern Insane Asylum	121	117	238	....	....	121.5	96.6	86.5	91.4
State Lunatic Asylum	111	45	156	....	....	87.2	92.3	42.1	68.6
Utah	**20**	**21**	**41**	**56.2**	**74.2**	**64.2**	**44.4**	**55.6**	**49.5**
State Mental Hospital	20	21	41	56.2	74.2	64.2	44.4	55.6	49.5
Vermont	**51**	**33**	**84**	**132.8**	**95.1**	**114.9**	**113.8**	**78.0**	**96.4**
Vermont State Hospital for the Insane	51	33	84	132.8	95.1	114.9	113.8	78.0	96.4
Virginia	**357**	**320**	**677**	**160.2**	**145.9**	**153.1**	**103.9**	**99.4**	**101.7**
Central State Hospital	152	167	319	170.6	194.9	182.5	127.2	145.5	136.2
Eastern State Hospital	60	37	97	153.5	95.6	124.7	87.0	63.8	76.4
Southwestern State Hospital	38	27	65	103.8	82.6	93.9	68.7	56.0	62.8
Western State Hospital	107	89	196	184.5	142.6	162.8	107.1	88.2	97.6
Washington	**227**	**104**	**331**	....	....	**97.8**	**73.7**	**60.8**	**69.1**
Eastern State Hospital	59	32	91	....	....	78.9	58.6	63.5	60.2
Northern State Hospital*	73	27	100	126.5	111.1	122.0	90.7	67.8	83.1
Western State Hospital	95	45	140	117.6	74.5	99.2	75.0	55.6	67.5
West Virginia	**181**	**119**	**300**	....	....	**123.4**	**98.4**	**79.9**	**90.1**
Huntington State Hospital	45	26	71	111.9	74.9	94.8	82.6	55.7	70.2
Spencer State Hospital*	53	21	74	....	....	121.9	109.5	66.9	92.7
Weston State Hospital	83	72	155	144.6	143.4	144.1	102.5	101.7	102.1
Wisconsin	**105**	**50**	**155**	**118.6**	**99.6**	**111.8**	**64.7**	**51.1**	**59.6**
Central State Hospital for the Insane	2	....	2	20.0	....	20.0	16.9	....	16.9
Northern Hospital for the Insane	40	19	59	101.5	79.8	93.4	54.9	42.0	50.0
Wisconsin State Hospital for the Insane	63	31	94	161.1	117.4	143.5	81.3	58.9	72.3
Wyoming	....	....	**16**	....	....	**66.9**	....	....	**50.8**
Wyoming State Hospital for the Insane	....	....	16	....	....	66.9	....	....	50.8

* Estimated from biennial report.

Table IX—Admissions of patients with mental diseases to state hospitals in 1910 and in 1918

(Includes only those states for which complete data were obtained.)

STATE	Admissions						Number Per 100,000 of General Population	
	in 1910			in 1918				
	Males	Females	Total	Males	Females	Total	In 1910	In 1918
Alabama	444	387	831	454	475	929	38.9	39.0
Arkansas	152	103	255	697	499	1,196	16.2	67.2
California	1,161	632	1,793	2,028	1,029	3,057	75.4	99.4
Colorado	233	120	353	244	165	409	44.2	40.8
Delaware	78	49	127	69	60	129	62.8	59.7
District of Columbia	426	171	597	886	168	1,054	180.3	283.8
Florida	196	129	325	.....	.....	693	43.2	74.7
Georgia	542	453	995	635	616	1,251	38.1	42.9
Illinois	1,499	1,148	2,647	3,705	2,484	6,189	46.9	98.6
Iowa	591	428	1,019	662	478	*1,140	45.8	51.2
Kansas	367	252	619	402	265	667	36.6	35.8
Louisiana	178	182	360	263	180	‡443	21.7	23.7
Maine	248	261	509	298	260	558	68.6	71.6
Massachusetts	2,070	1,871	3,941	2,928	2,756	5,684	117.1	149.4
Michigan	870	654	1,524	1,399	1,083	2,482	54.2	79.7
Minnesota	858	547	1,405	1,301	735	2,036	67.7	87.4
Missouri	675	489	1,164	741	563	1,304	35.3	37.9
Montana	212	66	278	436	154	590	73.9	123.0
Nebraska	243	168	411	322	235	557	34.5	43.2
Nevada	45	11	56	52	14	66	68.4	58.5
New Hampshire	157	143	300	236	210	446	69.7	100.1
New Jersey†	528	429	957	691	658	1,349	37.7	44.3
New Mexico	60	24	84	82	52	134	25.7	31.1
New York	4,186	3,646	7,832	5,017	4,737	9,754	85.9	92.4
North Carolina*	390	433	823	.....	.....	750	37.3	30.6
Ohio	1,676	1,171	2,847	2,186	1,477	3,663	59.7	69.9
Oregon	447	143	590	523	310	833	87.8	95.2
Pennsylvania	880	654	1,534	1,105	736	1,841	20.0	21.1
Rhode Island	211	167	378	279	198	477	69.7	75.5
South Carolina	338	308	646	524	477	1,001	42.6	60.6
South Dakota	126	73	199	143	95	238	34.1	32.8
Tennessee	344	277	621	455	462	917	28.4	39.6
Texas	689	576	1,265	768	630	1,398	32.5	30.7
Utah	66	37	103	110	86	196	27.6	43.7
Vermont	83	59	142	112	90	202	39.9	55.3
Virginia	691	543	1,234	783	697	1,480	59.9	66.6
Washington	609	275	884	737	362	1,099	77.4	67.5
West Virginia	266	229	495	483	395	878	40.5	61.6
Wisconsin	703	417	1,120	716	480	1,196	48.0	47.1
Wyoming	30	12	42	.....	.....	71	28.8	37.8

* Not including hospital for criminal insane.
† 1919 data.
‡ Estimated from biennial report.

Table X—Deaths of patients with mental diseases in state hospitals in 1910 and 1918

(Includes only those states for which complete data were obtained.)

STATE	Deaths						Death Rate Per 1,000 Patients Under Treatment	
	in 1910			in 1918				
	Males	Females	Total	Males	Females	Total	In 1910	In 1918
Alabama	157	170	327	268	267	535	113.9	146.4
Arkansas	68	50	118	247	143	390	87.6	121.3
California	397	191	588	700	349	1,049	70.4	78.6
Colorado	50	16	66	119	74	193	53.4	93.8
Connecticut	144	114	258	.....	.....	474	68.9	97.5
Delaware	23	25	48	44	28	72	84.5	113.7
District of Columbia	206	73	279	247	86	333	80.0	77.5
Florida	76	42	118	286	189	475	100.5	208.9
Georgia	236	210	446	383	313	696	109.4	130.8
Illinois	567	410	977	1,508	907	2,415	73.8	97.7
Iowa†	248	147	395	301	189	490	76.8	78.3
Kansas	148	66	214	253	122	375	68.4	91.3
Louisiana	74	72	146	86	50	136	64.2	45.7
Maine	83	83	166	137	98	235	93.9	103.1
Massachusetts	619	504	1,123	973	742	1,715	73.6	79.5
Michigan	372	221	593	478	350	828	80.5	87.4
Minnesota	249	134	383	328	201	529	62.4	63.8
Missouri	262	195	457	466	268	734	84.8	111.2
Montana	60	12	72	97	46	143	73.8	85.1
Nebraska	116	58	174	180	111	291	72.5	93.4
Nevada	13	8	21	35	6	41	73.4	128.9
New Hampshire	78	63	141	74	80	154	119.9	91.7
New Jersey	173	135	308	*301	*296	*597	70.7	*97.2
New Mexico	32	7	39	56	31	87	128.7	188.3
New York	1,445	1,190	2,635	2,146	1,765	3,911	69.4	82.3
North Carolina	112	98	210	.....	.....	†443	63.2	†99.7
Ohio	681	413	1,094	897	606	1,503	82.8	91.8
Oregon	119	34	153	152	79	231	71.0	78.5
Pennsylvania	315	253	568	576	402	978	62.3	80.2
Rhode Island	64	48	112	125	103	228	75.7	103.6
South Carolina	150	147	297	243	234	477	135.8	148.6
South Dakota	50	24	74	73	23	96	73.8	73.7
Tennessee	88	84	172	155	157	312	70.0	101.0
Texas	195	143	338	308	211	519	64.4	71.6
Utah	19	18	37	20	21	41	83.1	49.5
Vermont	31	21	52	51	33	84	72.8	96.4
Virginia	239	182	421	357	320	677	86.5	101.7
Washington	168	52	220	227	104	331	76.6	69.1
West Virginia	98	76	174	181	119	300	78.5	90.1
Wisconsin	84	39	123	105	50	155	51.8	59.6
Wyoming	6	5	11	.....	.....	16	53.9	50.8

* 1919 data.
† Not including hospital for criminal insane.

NOTES AND COMMENTS

Convention of Mental Hygiene Societies

The Third Convention of Mental Hygiene Societies will be held under the auspices of the National Committee for Mental Hygiene and in coöperation with the Mental Hygiene Committee of the State Charities Aid Association in New York City, February 4th and 5th in connection with the eleventh annual meeting of the National Committee. In addition to special meetings for delegates from societies, at which will be discussed current problems in organized mental-hygiene work, three public meetings will be held—two at the Waldorf-Astoria and one at the New York Academy of Medicine. The meeting at the Academy of Medicine on the evening of February 4th is arranged especially for physicians, although the public is invited. Dr. Walter B. James, President of the National Committee, will preside. Papers will be read by Dr. E. E. Southard, Director of the Massachusetts Psychiatric Institute, on mental hygiene of industry; and Dr. Thomas W. Salmon, Medical Director of the National Committee for Mental Hygiene, on psychiatry in medical schools.

At a meeting on the afternoon of February 5th at the Waldorf-Astoria will be discussed the mental hygiene of childhood. Miss Julia C. Lathrop, Chief of the Children's Bureau, Washington, D. C., will preside. Papers will be read by Dr. John B. Watson, Johns Hopkins University, Baltimore; Dr. C. Macfie Campbell of the Henry Phipps Psychiatric Clinic, The Johns Hopkins Hospital, Baltimore; Dr. William A. White, Superintendent, St. Elizabeths Hospital, Washington, D. C.; and Dr. E. Stanley Abbot, Medical Director, Mental Hygiene Committee, Public Charities Association of Pennsylvania.

The closing meeting will be held at the Waldorf-Astoria on the evening of February 5th. The Surgeon General of the United States Army, Major General Merritte W. Ireland, will preside. The results of the neuropsychiatric work in the army, both abroad and in the American camps, will be discussed, with application to civil problems. Papers will be read by Dr. Harvey H. Cushing of the Neuro-surgical Department, Peter Bent Brigham Hospital, Boston; Dr. Pearce Bailey, Chairman of the New York State Committee on Mental Defectives, and formerly Chief of the Neuropsychiatric Division in the Office of the Surgeon General, Washington; and Dr. Thomas W. Salmon, formerly Senior Consultant in Neuropsychiatry of the American Expeditionary Force.

Canadian National Committee for Mental Hygiene

Work for Returned Soldiers

The committee has assisted in securing adequate treatment for the 5,000 men who returned from overseas suffering from mental and nervous disorders. Under the authority of the Department of Soldiers' Civil Reëstablishment, hospitals for the insane in western Canada caring for military cases were inspected, and better treatment ensued. Thirty-four nurses of the department were given a training in mental hygiene by the committee. These aids are now doing splendid work in assisting mental and nervous military cases to accommodate themselves to civilian life.

Immigration

A study made by the committee in various parts of Canada demonstrated that half of Canada's feebleminded and insane population had come from countries outside of the Dominion. These data were presented to the Minister of Immigration and Colonization, and were responsible in no small measure for the enactment of comprehensive laws at the last session of Parliament—laws that have as their purpose the barring of undesirables from Canada. Arrangements have been made for the committee to give a course of training in the diagnosis of mental disorders to inspectors at Canadian ports of entry.

Mental Hygiene Activities in the Various Provinces

(a) Manitoba

At the request of the Public Welfare Commission of the Manitoba Government, a mental-hygiene survey of this province was conducted in the fall of 1918. The facts collected demonstrated that adequate measures had not been taken either with regard to the prevention or to the suitable treatment of mental abnormality. The failure to adopt an enlightened program had resulted in the clogging of jails, reformatories, and other institutions for dependents and delinquents, with the feebleminded and insane—a condition of affairs that rendered impossible the conduct of these organizations for the purposes for which they were designed. Insanity had been looked upon as a species of crime, and patients were thrown into jail before being transferred to hospitals for the insane. The hospitals themselves were merely custodial boarding-house institutions that provided little in the way of active treatment. One institution had 700 patients, with but one physician in charge. The patients were found to be sitting in rows, staring into space, vegetating, and apparently waiting for death.

The committee submitted a report, together with recommendations, and action immediately followed. Among the reforms was the adop-

tion of a system by means of which an effort will be made to decide cases of mental abnormality in their early stages, and measures for the treatment of such are being inaugurated. By means of mental clinics, court cases, public-school children, and prospective inmates of the various provincial institutions will be given mental examinations. Treatment will thus be prescribed according to individual needs. A group of buildings has been set aside for a training school for mental defectives. The system of special classes for retarded or peculiar children will be enlarged. Not only will the existing hospitals for the insane be transformed from mere asylums to hospitals for active treatment, but a psychopathic hospital for the observation and treatment of early acute cases has also been provided. The laws relating to the admission of patients to hospitals have been revised.

The committee is being called in consultation from time to time with the Manitoba authorities to assist in putting this most progressive program into successful operation.

(b) British Columbia

A mental-hygiene survey was conducted in this province in the middle of 1919. Although the report of the findings and the recommendations were only recently submitted to the government, action has already been taken with regard to various matters. Plans are now under way to erect a modern training school for mental defectives, to institute a building for the treatment of acute cases of mental disease, and to bring about many other changes.

(c) New Brunswick

The committee has just received a request from the Government of New Brunswick to conduct a comprehensive mental-hygiene survey of the province at the earliest possible date.

(d) Ontario

The committee has prepared the soil for a far-reaching program of reform, and has already accomplished much of value. A survey was made, in conjunction with the Municipal Department of Public Health, of 15,000 school children, and the Board of Education of the City of Toronto has accepted the committee's recommendation concerning the establishment of special classes. A study was made of the children attending the Guelph public schools, and the board of education of that city has put in operation the auxiliary special class system.

A reception hospital to be built upon the lines of a psychopathic institution will be built at an early date in Toronto, and this has been brought about in no small measure by the committee.

As the result of facts collected by the psychiatric clinic, which is under the supervision of the Medical Director of the Canadian

National Committee, a training school for mentally deficient children will be erected on the outskirts of the City of Toronto. An initial appropriation of $150,000 has been granted for the purpose.

In addition to the activities outlined above, special studies have been undertaken in Toronto. The studies include investigations into public-school problems, juvenile delinquency, prostitution, illegitimacy, and industrial psychology.

(e) Quebec

The committee has been fortunate in this province in securing the coöperation of French and English in establishing a progressive mental-hygiene program. The superintendent of hospitals for the insane for the province is a member of the executive committee, and is sending a number of his lieutenants abroad for a thorough psychiatric training. The committee has placed at his disposal a social worker who devotes her time to supervising paroled patients from mental hospitals, and assists these cases in rehabilitation. In the near future this work will be extended.

An associate medical director of the Canadian National Committee was appointed for work in Quebec, and has a staff composed of an associate psychiatrist, two social workers, and a stenographer. The Protestant Board of School Trustees of the City of Montreal has empowered this associate medical director to conduct a school survey. In addition, arrangements have been made for the mental examination of the boys at Shawbridge Industrial School. Valuable work has been done in determining the mental status of women leading immoral lives, and a psychiatric clinic has been established in connection with the Royal Victoria Hospital.

(f) Other Provinces

An active educational publicity campaign through the daily press, on the public platform, and by exhibits, has been conducted in all the provinces of Canada.

Medical Directors of State Societies for Mental Hygiene

Four state societies for mental hygiene have recently appointed medical directors or executive secretaries. Dr. A. Warren Stearns has been appointed Executive Secretary of the Massachusetts Society for Mental Hygiene. Doctor Stearns was formerly an assistant physician at the Boston Psychopathic Hospital, and during the war was in charge of the psychiatric examinations at the United States Naval Training Station, San Francisco, California.

Dr. Ralph P. Truitt has been appointed Medical Director of the Illinois Society for Mental Hygiene, and is giving full time to the direction of the work of this organization. Doctor Truitt was formerly

an assistant physician at the Trenton, New Jersey, State Hospital, and the Louisiana State Hospital. During the war, Doctor Truitt served as a major in the Neuropsychiatric Division of the Medical Corps, being in charge of the psychiatric examinations at Camp Funston, and later as an assistant director of the course in disciplinary psychiatry at the United States Army Disciplinary Barracks, Fort Leavenworth.

The Connecticut Society for Mental Hygiene has appointed Dr. William B. Terhune as its medical director. Doctor Terhune was formerly an assistant physician at the East Louisiana State Hospital. During the war he served as a lieutenant in the Neuropsychiatric Division of the Medical Corps, and was assigned to Base Hospital No. 5, A. E. F.

Dr. E. Stanley Abbot has been appointed Medical Director of the Mental Hygiene Committee of the Public Charities Association of Pennsylvania. Doctor Abbot was formerly on the staff of the McLean Hospital in Boston. During the war he served as a major in the Neuropsychiatric Division of the Medical Corps, being chief of the Neuropsychiatric Service, U. S. Army General Hospital No. 26, Ft. Des Moines, Iowa.

The Connecticut Society for Mental Hygiene

On the first of October, 1919, the Connecticut Society for Mental Hygiene inaugurated an intensive state-wide campaign for the practical application of the principals of mental hygiene. This followed as the logical result of the decision of the executive committee during the summer of 1919 that the time was appropriate for an extension of the activities of the society. It is worthy of note that this society was the first organized effort for the amelioration and prevention of mental disease and defect. It was organized in 1908 by Mr. Clifford W. Beers, who is at present Secretary of the National Committee for Mental Hygiene. Since its organization, the membership has increased steadily and the society has exerted influence throughout the state in matters relating to mental hygiene.

Since October first, the working staff has been reorganized: a full-time medical director has been employed, the services of Dr. William B. Terhune having been secured for this position; a full-time secretary with psychiatric training has also been employed; the office force has been increased; and psychiatric field workers have been established in centers of population.

An educational campaign is being carried on by means of newspaper publicity, pamphlets, lectures, community conferences, and exhibits. The public has shown a genuine interest in this phase of

the work. Clinics for the examination, diagnosis, and treatment of mental disease and defect have been established in New Haven and Waterbury and are conducted by the medical director. Clinics have been established in other cities of the state and are being conducted by psychiatrists residing in the localities of the clinics. These clinics are demonstrating what can be accomplished by the early diagnosis and treatment of mental disease.

The society has undertaken, to a limited extent, the care of discharged neurotic soldiers and is assisting them to readjust themselves to civilian life. This work is being conducted in coöperation with the United States Public Health Service and the Home Service Department of the American Red Cross. The activity of the society in this direction is only temporary, as it is felt that the number of neurotic discharged soldiers needing assistance will rapidly decrease when the government provides adequate care for these patients.

Another important innovation in the mental-hygiene work of the state is a system for following up all patients discharged or paroled from the state hospitals. This is done with a view to assisting these patients in every possible way and preventing recurrence of their mental disorders.

A state-wide study of the prevalence of feeblemindedness and the care of the feebleminded is being made. When the available information on this subject is assembled, an effort will be made to provide more adequate care for this group.

The Massachusetts Society for Mental Hygiene

Besides the annual conference held regularly in Boston, the Massachusetts Society for Mental Hygiene is this year holding additional conferences in other cities in the state. The first conference was held in Pittsfield, September 29. The conference was well attended and aroused much interest. On November 14, a second conference was held in Worcester. Dr. Samuel B. Woodward presided, and the following papers were read: *A State Program for the Care of the Feebleminded,* by Dr. Walter E. Fernald, Superintendent of the Massachusetts School for the Feebleminded; *Mental Hygiene and the Schools,* by Professor William H. Burnham, Professor of Pedagogy and School Hygiene, Clark University; *Grail or Dragon; Notes on the Prime Task of Humanity,* by Dr. E. E. Southard, Director, Massachusetts State Psychiatric Institute, Boston.

The Illinois Society for Mental Hygiene

The offices of the society, including the social service and occupational departments, workshops, and office of the medical director, are

now located at 2816 Michigan Avenue, Chicago. A clinic is held daily at the offices of the society. In addition to this clinic, a coöperative arrangement has been made with the clinic at the University of Illinois, College of Medicine, which makes it possible for the medical director to examine at the college clinic cases referred to the society from the neighborhood of the College of Medicine and to provide hospital observation and treatment for those in need of it. It is expected that coöperative relationships with other clinics in the city will be established.

Four psychiatric social workers are engaged in the department of social service. More workers are needed, and it is expected that the number will be increased in the near future and a permanent director for this department appointed. Of the four workers at present employed, one is devoting her entire time to work with ex-service men, one to adult civilian patients, one to unusual children, and one to occupational work.

The occupational-therapy department, which rendered valuable assistance to the government during the war in the training of reconstruction aids, is continuing the training work, but is assuming more its original purpose as a therapeutic center for the mentally handicapped.

At the annual meeting of the society held in October, a reorganization was made, the most important result being the appointment of a series of committees, the chairman of each committee to be a member of the executive committee. These committees are: a Headquarters Committee, a State Work and Legislative Committee, a Publicity and Membership Committee, a Finance Committee, and a Special Problems Committee.

Mental Hygiene Committee of the Public Charities Association of Pennsylvania

Professor Norbert J. Melville, Special Secretary of the Public Charities Association, was active in securing the passage of the bill amending the school code providing for mental as well as physical examination for all exceptional children in public schools. (See page 200.) Professor Melville and the Mental Hygiene Committee of the association are coöperating with the Departments of Public Instruction and Public Health in carrying out the provisions of this measure.

Clinics

Since July 1, Miss Frances M. Cashel, a psychiatric social worker, has been acting under the direction of the Mental Hygiene Committee of the association, but having temporary headquarters with the Home

Service Section of the Red Cross, to aid discharged soldiers, sailors, and marines who show nervous or mental disability. The value of her work and the need of skilled advice led to the appointment by the Red Cross of Dr. Frederick H. Leavitt as psychiatrist. Dr. Leavitt holds a daily clinic at the rooms of the Home Service Section.

Meeting of the Mental Hygiene Committee

The first fall meeting of the Mental Hygiene Committee of the association was held on October 29. Several invited guests were present. The mental-hygiene situation in Pennsylvania was outlined, and the opportunities afforded by the amendment to the school code and by the prospective revision and codification of the laws relating to the insane and feebleminded were especially dwelt upon. Doctor Thomas W. Salmon, of the National Committee for Mental Hygiene, spoke of the work of the Public Health Service in caring for mentally disabled soldiers, sailors, and marines, and urged the coöperation of the committee in this work. It was voted to devote the major efforts of this committee to these three fields, though other lines of mental-hygiene work are not to be neglected. Dr. Owen Copp was elected chairman of the committee, and was authorized to appoint an executive committee to act for the general committee.

The Maryland Society for Mental Hygiene

In November the Maryland Society for Mental Hygiene held its first annual conference, the general subject of the conference being "Modern Psychology Applied in the Classroom." Two sessions were held. Dr. Edward N. Brush, President of the Society, presided at one and Mr. James W. Chapman, Jr., President of the Baltimore Board of School Commissioners, the other. Papers were read by Dr. Agnes L. Rogers, head of the Department of Education, Goucher College; Dr. Adolf Meyer, Director of the Henry Phipps Psychiatric Clinic; and Dr. William H. Kilpatrick, Professor of Education, Teachers College, Columbia University. The Hon. William F. Broening, Mayor of Baltimore, contributed a paper on Plans for Improving the Baltimore Public Schools.

Mississippi Society for Mental Hygiene

At a meeting held in Jackson in October the Mississippi Society for Mental Hygiene was formally organized. Professor W. H. Smith, President of the Agricultural and Mechanical College of Starkville, was elected president; Mr. Preston, formerly State Superintendent of Education, vice-president, and Dr. J. H. Fox, of Jackson, secretary

and treasurer. Dr. Frank P. Norbury, who during the war served as the Acting Medical Director of the National Committee for Mental Hygiene, represented the National Committee at the organizing banquet. The first active work of the Mississippi Society will be in connection with the survey of the Mississippi Mental Hygiene Commission, being made by Dr. Thomas H. Haines, and the forwarding of such legislation will come as a result of this survey.

Province Society for Mental Hygiene—South Africa

A society for mental hygiene has been organized at Cape Town, South Africa. Affiliated with the society is the Cape Town Committee for Mental Defectives. The committee maintains a home for mentally defective women and has recently purchased three houses and thirty acres of land. At the Third Annual Child Welfare Conference, held in September at Durban, Natal, Union of South Africa, a resolution was passed urging the formation in each province of the Union of a provincial society for mental hygiene, and that such societies unite to form a National Committee for Mental Hygiene. In connection with this resolution, a resolution passed at the conference in 1918 was reaffirmed: that the "conference press upon the government the urgent need of immediate adequate provision to be made for the care, education, and training of the feebleminded, including the establishment of suitable institutions, and the appointment of medical experts, who shall furnish the authorities with reports on the different schools as regards the number of feebleminded children attending, to enable Section 5, Chapter I of Act 38 of 1916, to be applied, and also to act as assessors in children's courts."

Mental Hygiene Legislation in Pennsylvania

House Bill No. 1055 of the Pennsylvania Legislature, an amendment to the school code, providing for the mental as well as the physical examination of all exceptional children in the public schools, the establishment of special classes and special schools, and the payment by the state of half the cost of maintaining the classes, as outlined in the April, 1919, number of Mental Hygiene, was signed by the governor July 22.

The Pennsylvania Legislature at its last session passed a resolution which provides for the appointment of a commission "to revise and codify the laws relating to the insane and feebleminded," with powers to draft bills and recommend such changes in existing laws as may seem desirable, "including, if deemed feasible, a comprehensive plan whereby these dependents of the state may be cared for under the authority of one board."

The Homeopathic State Hospital at Allentown opened a new outpatient clinic at Bethlehem on November 10. This is the third to be established by that hospital, the other two being at Easton and Allentown, respectively. All are conducted by Dr. Henry I. Klopp, Superintendent.

Plans for the early opening of the Village for Feebleminded Women at Laurelton, Pennsylvania, are under way. It will have a capacity of 200 beds.

Alabama Home and School for Mental Deficients

A home and school for mental deficients or inferiors has been authorized by the 1919 legislature of Alabama. This institution is to be located upon or near the site of the Bryce Hospital, one of Alabama's two hospitals for mental diseases, near Tuscaloosa.

The following are classified to be mental inferiors or deficients or feebleminded in accordance with the act: "All persons of whatever age who are deficient or inferior to the extent of being classed in either of the following groups of the feebleminded: that is to say, idiots, imbeciles, feebleminded, or morons, and any of whom may be, or may not be, epileptics, but not violent or insane.

"The terms 'feebleminded' and 'mental inferior or deficient,' within the meaning of this act, shall include every person with such a degree of mental defectiveness from birth, or from an early age, that he is unable to care for himself and to manage his affairs with ordinary prudence, or that he is a menace to the happiness or safety of himself or of others in the community, and requires care, supervision, and control either for his own protection or for the protection of others.

"Any person within the above-named class, over the age of five years, and a resident of the State of Alabama for more than a year, may be committed to the home."

The act provides for the transfer of patients from this institution to the two state hospitals for mental diseases and for the reception of patients from the state hospitals who are found not to be insane, but to be mentally inferior or deficient as defined in this act.

Provision is made for commitment to this home through court procedure upon the application of a relative, guardian, or other person interested in the individual to the judge of the juvenile court or to the probate judge of the county. Sterilization is authorized when it is deemed advisable by the superintendent of the home and the superintendent of the Alabama insane hospitals. Parole is also provided for by the act for such length of time as seems advisable, when the

superintendent of the home is satisfied that the inmate will be properly cared for and when in his opinion parole will not be detrimental to the community.

"The buildings for the home shall be located, built, and equipped so as to facilitate the proper classification of residents according to age, sex, color, and grade of deficiency or inferiority, their employment and training in farming and gardening, mechanics or other useful industries or occupations, and to make provisions for schools, church worship, amusement, and diversion that may be conducive to the health, happiness, and moral and mental improvement of the residents."

"Whenever the superintendent of the hospitals is informed that there is a person confined in a poorhouse, a jail, an orphanage, or a boarding school in the state of Alabama who should be a resident of the home, it shall be his duty to examine in person, or through the superintendent of the home, or by other proper deputy, every such person, and if such person is found to be a mental inferior or a feebleminded person as herein defined, and otherwise eligible for admission to the home, he must make an order transfering such mental inferior from such poorhouse, orphanage, reformatory, or boarding school to the home, and the judge of probate of the county from which the defective person comes shall provide the means necessary to transport such defective person to the home."

This act carries an appropriation of $50,000 a year for four successive years.

Two Psychiatric Buildings for Alabama

The 1919 legislature appropriated $150,000, subject to the approval of the governor and the funds being available in the treasury, for the erection at the Bryce Hospital, near Tuscaloosa, Alabama, of two psychiatric buildings, one for each sex. An adequate psychiatric staff is planned to make intensive clinical studies of all new patients coming to the hospital.

Delaware Home for the Feebleminded

Ground has been broken for the construction of the new home for the feebleminded, which was authorized by the 1917 legislature and is to be located near Stockley. Three buildings are to be constructed, but at the present time only one will be used. The site includes about eight hundred acres, two hundred of which are cleared. The remainder is woodland. The land was purchased through funds raised by private subscriptions.

Mississippi Mental Hygiene Commission

Dr. Thomas H. Haines, Scientific Advisor to the Mississippi Mental Hygiene Commission, has completed his survey on the subject of feeblemindedness in that state and has made his report to the commission. On the basis of this report, the commission has in preparation two bills, one providing for a commitment law and an institution for the feebleminded, the other a new law pertaining to the care for patients in the state suffering from mental disease. If passed, this law will place Mississippi among those states that are making an earnest effort to prevent mental disease and to provide treatment for those who are ill, on a scientific basis. The law provides for proper scientific facilities, experienced medical treatment, voluntary and temporary care, observation, and community work in connection with out-patient departments and psychiatric social work.

Mental Hygiene Division of the Connecticut State Department of Health

The Connecticut State Department of Health has established a Division of Mental Hygiene and has appointed Dr. William B. Terhune, Medical Director of the Connecticut State Society for Mental Hygiene, medical director of the new division. Connecticut thus has the distinction of establishing the first Division of Mental Hygiene in a state department of health. A similar division was created in 1919 in the Department of Health in the city of Newark, New Jersey.

A Directory of Out-patient Clinics

A directory of out-patient clinics in the United States for nervous and mental patients has recently been completed by Dr. Clarence J. D'Alton, special assistant to the War Work Committee of the National Committee for Mental Hygiene. The directory includes the names of 225 clinics, their locations, the names of the directors, the hours at which patients are seen, and the types of patients for which the various clinics are planned. The directory will be of value to community social workers and to those working in connection with the American Red Cross, the army, and the Public Health Service. Copies can be obtained without charge from the National Committee for Mental Hygiene.

Mental Hygiene Clinics in Georgia

The trustees of the state sanitarium at Milledgeville during the summer established a mental clinic at Macon. This clinic is becoming of real service to the community and the public schools. Dr. Walker, assistant physician at the state sanitarium, is director of the clinic.

A mental-hygiene clinic has also been established in Atlanta. The clinic is under the direction of Dr. Funkhouser, Professor of Pediatrics in the Medical Department of Emory University. Dr. Owensby and Dr. Bronner are the psychiatrists attached to the clinic, while Professor White, head of the Department of Psychology at Emory University, has charge of the psychological work.

Psychiatric Social Service

At the Johns Hopkins University a course in social economics was instituted in October. This includes the study of political economy, social reform, and social case work. Supervised field work with established social agencies is arranged. With the excellent opportunities for psychiatric field work at the Phipps Clinic and the Shepard and Enoch Pratt Hospital, it is to be hoped that a training in psychiatry will be added to the course, so that the country may have another much needed source of supply of psychiatric social workers.

A demonstration of the value of psychiatric social work which is being watched with interest is that in progress at the Mental Hygiene Bureau of the Newark Department of Health. Newark is the first city in the country to establish such a bureau, and a qualified social worker was installed there on September first. She has already secured the cordial coöperation of all local agencies, and the bureau is dealing with cases referred from schools, courts, Red Cross bureaus, and charitable organizations.

In response to repeated requests from nursing and social-service organizations. Teachers College, Columbia University, has recently established a lecture course on various aspects of hospital social service. Field work in the various special divisions of the work will be arranged in the second half of the academic year. The course in mental hygiene is given by Dr. Charles I. Lambert, Bloomingdale Hospital, and special lectures on psychiatric social work will be given by Dr. Cheney, New York Psychiatric Institute, and Dr. McCurdy, Cornell Medical School.

The Missouri School of Social Economy of the University of the State of Missouri has this year added to its curriculum a course in psychiatry for social workers, given by Dr. Francis M. Barnes, Jr., of St. Louis. This year the work is offered as a special extension course for actively engaged social workers, and not to the student body as a whole. The course will cover a period of at least eleven weeks. It will consist of lectures once a week for ten weeks; demon-

strations of cases of mental disorder at the St. Louis City Sanitarium; assignment of cases for field work; personal interviews and discussions between the social worker and Dr. Barnes on the problems presented in the field work; supplementary reading.

It will be the purpose of the course to give the social worker such information on the subject of mental hygiene that she may be able to recognize and utilize the mental factors which enter the causation of social inadequacies. Psychiatry will be presented with the intention of assisting the social worker and not to make of her a psychiatrist.

The Smith College Training School for Social Work

On August 30 the first summer session of the Smith College Training School for Social Work was successfully completed. Courses were offered in psychiatric social work, medical social work, community service, and child welfare. Although the registration was smaller than in the 1918 training school for psychiatric social work, this year's course in that subject attracted more interest than did the courses in medical social work and in community service, eighteen students registering in the former and only six in each of the other two.

Ten students received certificates of attendance, six of whom, at the close of the summer session, had completed the course in the theory of psychiatric social work. Eighteen students are now doing practice work in Boston and Philadelphia. This year, because of the small size of the group, all of the students in psychiatric social work are receiving their practical training in Boston. The students in medical social work and community service are training in Boston and Philadelphia.

A novel feature of the period of practical training is an experiment in group living. Several of the students in training for psychiatric social work are living in Boston's South End on a coöperative-housekeeping arrangement, and their apartment is the local headquarters for Smith students who are training in Boston. The same plan has been adopted by a group of the medical students in Philadelphia. This arrangement carries over into the period of field training the associations and professional atmosphere of intensive study formed during the eight weeks' summer session in Northampton.

Correspondence Course in Social Psychiatry

Dr. A. Warren Stearns, Executive Secretary of the Massachusetts Society for Mental Hygiene, is conducting for the American Red Cross a correspondence course in the elements of social psychiatry. The course has been arranged at the request of workers who are

unable to leave home to study, but who find that they are often called upon to assist patients with nervous or mental disease. It is, of course, not the aim of those in charge of the work to prepare psychiatric social workers by this means, but to give the general worker a more comprehensive knowledge of the nature of her problems in so far as this can be done by printed lectures, directed reading, and corrected quizzes.

The course is divided into four parts, as follows: 1. Covers general psychiatry and classification of mental diseases. Each form of mental disease will be taken up with the special social problems created by each class; 2. Takes up the various dependent classes, such as paupers, criminals, incompetent housewives, and social misfits in general, and analyzes them in terms of mental disease; 3. Discusses facilities for the care of nervous and mental cases and their use, and supervision of such cases in the community; 4. Takes up the technique of social psychiatry, with special reference to the interview, history, records, and more personal side of the work.

Each student is furnished regularly with lectures prepared by Doctor Stearns and lists of assigned reading. Written quizzes are held at the end of each month. These are corrected by Doctor Stearns and returned to the student.

Reconstruction Aid to Serbia

Miss Meta L. Anderson, formerly supervisor of ungraded classes in the Newark, New Jersey, public schools, and during the war a reconstruction aid at Base Hospital 117 (for war neuroses) in France, has sailed for Europe, where she will take charge of the work for children under the Serbian Relief Commission.

A Survey in Missouri

At the request of the Governor of Missouri, the National Committee for Mental Hygiene has undertaken a survey of the care of the insane in that state. The survey is in charge of Dr. Samuel W. Hamilton, formerly First Assistant Physician at the Utica (New York) State Hospital, and more recently psychiatrist to the Army of Occupation, Coblenz, Germany.

Child Welfare Committee on Mental Hygiene

The Methodist Child Welfare Society of the Methodist Episcopal Churches of America has appointed a committee on mental hygiene. The society serves as a clearing house of social information on child welfare for the Methodist churches of the country.

A Christmas Thought

Two Versions

I

A woman lunatic has died in Rainhill (Lancashire) Asylum, where she had been an inmate for forty-five years at a cost of nearly £1,200 to the rate payers.—*London Daily Mail,* December 25, 1918.

II

An Englishwoman, helpless through incurable mental illness, has died in Rainhill (Lancashire) Hospital, where for forty-five years she received care and protection. The cost to the rate payers of thus faithfully carrying out the injunction to love one another was only ten shillings a week—less than the cost of keeping a beast of burden.—T. W. S.

The New Impulse in Mental Hygiene

Dr. Jessie Taft, Director of the Department of Child Study of Seybert Institution, Philadelphia, contributes an interesting article, *The New Impulse in Mental Hygiene,* to the October number of the *Public Health Nurse.* After discussing the need found by the medical corps of the various armies to provide for patients with nervous and mental disease, Dr. Taft has the following to say in regard to the development of the psychiatric social worker:

"The most far-reaching results for mental hygiene, however, have been obtained in a very different field. It is in the world of social work that we see developments which are nothing short of revolutionary in their effects. No war has ever depended for the winning on organization of social forces as has this war; consequently every factor of vital importance within the army itself had its roots far back in the social structure behind it. Its strength and growth, its repair and renewing, were found to rest upon the vitality and efficiency of the social base. The physical health of the soldiers, upon which victory so largely depended, was seen to involve a whole system of sanitation, public health, and social hygiene throughout the country, including the civilian population. We owe the greatest strides ever made in sex education and in the fight against venereal disease to the pressure of this war.

"In the case of mental hygiene, the process was slower and more indirect, but similar. The organization of social forces over here, to

meet the recognition of the supreme importance of mental health for winning the war, was much less prompt and thorough than was the organization for social hygiene. In fact, it is only now getting on its feet.

"The first demand for social support came in the call for social workers and occupational teachers to help in the reëducation of the shell-shocked men in the hospitals in France. Then there arose the problem of how to get psychiatric social service for the military hospitals here, which would have hundreds of mental patients to care for before the end of the war. There seemed no solution to this problem. There were, at the time the United States entered the war, only a very few experienced psychiatric social workers in the country, and there was no course offered anywhere for the training of such workers.

"Mental hygiene should be grateful to the necessity which mothered the invention of the first training course for psychiatric social work in the world. It was given at Smith College, in the summer of 1918, as a war-emergency measure, under the auspices of the National Committee for Mental Hygiene and the Psychopathic Department of the Boston State Hospital. The standards were high and the sixty or more young women who finally qualified were as fine a group as could have been desired. A large number were college graduates, and the rest had had equivalent preparation in other training and experience. Theoretical work was concentrated into eight weeks. Psychiatrists of note from every large city in the East came to lecture to that earnest body of students. It was as good for the psychiatrists as it was for their hearers. They went away with a new appreciation of the part social service was to play in the psychiatry of the future and a deepened respect for the professional social worker.

"The winter following this course saw these sixty students distributed among the hospitals and clinics in the East, wherever practice work under adequate supervision could be obtained. Because of the dearth of psychopathic hospitals and hospitals for the insane with efficient social-service departments, several students went to the Charity Organization Societies of New York and Philadelphia to work under the leadership of experienced case workers, who had been sent by their far-seeing societies to take the Smith course.

"The contribution which the supervision of these psychiatric students has made to mental hygiene can hardly be overestimated. Not so much the training course, nor even the work of the students, excellent as it was, but the centering of attention upon the work these young women represented was the source of a remarkable and penetrating change whose final results are not yet perceived.

"These effects have been felt in two quite opposite directions—

amusingly opposite, in fact. That these students who were humbly seeking knowledge should have been the instruments of education for both the social and the psychiatric 'powers that be' is another amusing feature of the first experiment in social psychiatry. Those who came to educate stayed to be educated. At least so it looks to some of us on the side lines who have been preaching social work to the psychiatrists and psychiatry to the social workers for some years past, with apparently little to show for our efforts. The exigencies of the war, however, secured the needed attention, and the presence of the students for six months, demanding practice work, compelled some sustained thought on the bearing of this war-emergency measure to the everyday work of the organizations in which they had been placed.

"The hospitals and clinics which consented to take the students for their practical work, by the mere fact that they did accept them, began to realize more keenly the importance of social service and to see the growing value placed on it by the world at large. Later on, when these same students were assigned to posts in various military hospitals, the education of the hospital physicians was continued, and many a man who thought a social worker as superfluous as a fifth wheel was gently, but firmly made to see the possibilities of social service for his patients.

"Within the Charity Organization Societies of New York and Philadelphia, the results have been even more tangible and transforming. In New York the district which undertook the training of the Smith students was given the particular use of one psychiatric clinic and the special interest and attention of one clinic physician. This concentrated attention on the mental factors of all the case work done by the Charity Organization Society. The psychiatrist at the clinic became so interested in their problem that he joined one of the district committees, so that he might be in closer touch with the work. District supervisors wanted to know more about the psychiatric side. Finally, under pressure of demand for lectures and courses, the New York School of Social Work secured Dr. Bernard Glueck, who offered a special course for social workers in which their case-work problems could be discussed in the light of the psychiatric approach. This department has grown, and its influence will be felt from now on in the training of every student who goes through the New York School of Social Work.

"In Philadelphia an even more remarkable development took place. The director of case work in the Society for Organizing Charity had herself attended many of the lectures at Smith and had been convinced of the essential contribution of psychiatry to all case work.

She felt that, not only mental cases, but every case ought to be approached from the psychological angle which psychiatry has used in understanding the mentally ill. She decided that every worker in her association ought to get the psychiatric point of view.

"The Pennsylvania School for Social Service, responsive to this newly felt need, decided to organize a six-months training course in social psychiatry similar to the Smith course, but with a change in emphasis. The lectures in psychiatry were to be open to any practicing social worker as well as to the students taking the entire course. The plan was carried through with tremendous enthusiasm. Every worker in the Society for Organizing Charity was in attendance. Workers representing practically every social agency in Philadelphia took advantage of the school's offer. For six months, seventy-five or more practicing social workers in Philadelphia attended weekly two-hour lectures given by the best psychiatrists in the East. It has been remarked that nothing has ever made so much difference in the case work of the Society for Organizing Charity. Another result has been the permanent organization of a training course in social psychiatry in the Pennsylvania School for Social Service.

"Such results as these are not temporary. They mean a gradual, persistent growth in the direction of a new psychology, a new comprehension of what mental hygiene means, a new psychological foundation for all case work. The fact that psychiatry and mental hygiene have become part of the curriculum of the schools for social work in Boston, New York, and Philadelphia means that the social workers of to-morrow will start on a different basis. This is the greatest impulse that the war has, all unwittingly, given to mental hygiene.

"Second only to the results in the schools for social service is the effect of the need of mental work on the home service of the Red Cross. The social care of hundreds of soldiers who have come back from France with a war neurosis, or even more serious mental condition, has fallen largely upon them. The hospitals discharge these men to a family or a community which is ignorant of what to do for them. The home service must take up the job. They did not realize for a long time that it meant anything different in the training of their workers, but gradually they are being compelled to organize mental or psychiatric departments for the care of the mental cases, and so the demand for trained psychiatric social workers increases and the good work of education goes on.

"If anything further was needed to convince one of the new life taken on by the mental-hygiene movement, attendance at the National Conference of Social Work at Atlantic City was all that was neces-

sary. It was a landslide for psychiatry. Evidence of the conversion of the psychiatrist and the social worker were to be seen on every hand. One eminent psychiatrist was heard to call himself a social worker. Social workers addressed audiences containing some of the best known psychiatrists in the country. Several psychiatrists were present through a large part of the conference. Mental-hygiene meetings were so popular it was necessary to change the place of meeting originally assigned for a larger hall. Altogether, it was a recognition of social work by psychiatry, and a request by the social worker for education in the understanding of human nature which the psychiatrist has. If there was any doubt in the mind of the conference as to the permanency and value of the Mental Hygiene Section, which came into being only a year ago, that doubt must have been dispelled. The day of obscurity for mental hygiene is past. From the new alliance between psychiatry and social work brought about by the war has sprung social psychiatry, the mental hygiene of to-morrow."

Library of the National Committee for Mental Hygiene

A Valuable Gift

Through the legacy of Major Morris J. Karpas, of the Neuropsychiatric Division of the Medical Corps of the U. S. Army, who died in service in France, the library was made a beneficiary by the gift of several hundred valuable medical books, including a number of important foreign works. This collection, which formed the greater part of Major Karpas' private library, will be a most significant addition to the library's material on psychiatry and neurology.

Library Open Evenings

Because of frequent requests from social workers and other readers for permission to use the library during the evening and on Saturday afternoons, a new time schedule has been arranged, providing for open hours on Tuesdays and Thursdays from 7:30-9:30 p. m. and on Saturdays until 6 p. m.

New Bibliography for Distribution

A limited number of copies of a list of *Selected References on Psychiatric Examination in Courts and Prisons* is available. These lists may be secured through application to the librarian.

Recent Accessions

Speech training for children, by M. G. and Smiley Blanton.

Essentials of social psychology, by E. S. Bogardus.

Dispensaries; their management and development, by M. M. Davis and Andrew Warner.

Rural problems of to-day, by Ernest R. Groves.
Modern treatment of mental and nervous disorders, by Bernard Hart.
Future of the disabled soldier, by C. W. Hutt.
Man's supreme inheritance, by F. M. Alexander.
Principles and practice of hydrotherapy, by Simon Baruch.
The third and fourth generation, by E. R. Downing.
School organization and the individual child, by W. H. Holmes.
Study of the mental life of the child, by H. von Hug-Hellmuth.
The unmarried mother, by P. G. Kammerer.
The organism as a whole, by Jacques Loeb.
The creative impulse in industry, by Helen Marot.
Philosophy of conduct, by S. A. Martin.
Mental capacity of the American negro, by M. J. Mayo.
Crime and criminals, by Charles Mercier.
War neuroses and shell shock, by F. W. Mott.
An American idyll, by C. S. Parker.
Rational sex ethics, by W. F. Robie.
Laws relating to sex morality in New York City, by A. B. Spingarn.
The third great plague, by J. H. Stokes.
Syphilis and the army, by G. Thibierge.
Mental deficiency—amentia, by A. F. Tredgold.
Psychological principles, by James Ward.
American charities, by A. J. Warner.
Manual of Mendelism, by James Wilson.
Psychiatric-neurologic examination methods, by August Wimmer.
A new conscience and an ancient evil, by Jane Addams.
Sex education, by M. A. Bigelow.
Rational sex life for men, by M. J. Exner.
Biology of sex, by T. W. Galloway.
The human machine and industrial efficiency, by F. S. Lee.
Annual report of the New York City Department of Health.
Education for character, by F. C. Sharp.
Problems of mysticism and its symbolism, by Herbert Silberer and S. E. Jelliffe.
Ventilation in relation to mental work, by E. L. Thorndike, W. A. McCall, and J. C. Chapman.
Right and wrong thinking, by Aaron Crane.
Legislation on insanity, by G. L. Harrison.

The International Conference of Women Physicians

The program of the International Conference of Women Physicians, in session from September 15 to October 26 in New York City, included a number of papers on mental-hygiene subjects. Some of the titles were: *Relation of Mental Factors to Disability,* by Dr. Thomas W. Salmon, New York; *Health and Morality in the Light of the Newer Psychology,* by Dr. Eleanor Bertine, New York; *Exploration of the Unconscious,* by Dr. Smith Ely Jelliffe, New York; *Outline Description of Personality,* by Dr. George S. Amsden, White Plains, N. Y.; *The Family Drama,* by Dr. Charles Lambert, White Plains, N. Y.; *Auto-eroticism,* by Dr. Horace W. Frink, New York; *Personality and Will in the Light of the Newer Psychology,* by Dr.

Beatrice Hinkle, New York; *The Function of Repression,* by Dr. John MacCurdy, Pleasantville, N. Y.; *Sexual Life of the Child,* by Dr. Leonard Blumgart, New York; *Extending the Field of Conscious Control,* by Dr. William A. White, Washington, D. C.; *The Psychology of Discontent,* by Dr. Adolf Meyer, Baltimore; *Education in Principles of Mental Hygiene,* by Dr. Frankwood E. Williams, New York; *Maladaptation and the Neuroses,* by Dr. Edith Spaulding, Northampton, Mass.; *Delinquency as a Reflection of Certain Social Settings,* by Dr. Bernard Glueck, New York; *A Re-interpretation of Childhood,* by Dr. Wilfrid Lay, New York; *The Creative Impulse in Industry,* by Helen Marot, New York.

Congress of the American Prison Association

The annual congress of the American Prison Association was held in New York City, October 20th to 24th.

Some of the papers of special interest in their bearing upon mental hygiene were: *The Practical Meaning of Mental Examinations,* by Dr. William Healy, of the Judge Baker Foundation, Boston; *Further Studies of Delinquent Personalities* and *Mental Diseases as Seen in Court,* by Dr. V. V. Anderson, of the National Committee for Mental Hygiene, New York; *Emotional States and Illegal Acts,* by Dr. John Oliver, Baltimore; *The Social Significance of the Study of Special Abilities and Disabilities,* by Dr. Augusta F. Bronner, of the Judge Baker Foundation; *A Study of Picture Completion Among Delinquent Children,* by Dr. Robert H. Gault, of the Department of Psychology, Northwestern University; *The Importance of Character Study in Criminology,* by Dr. Guy G. Fernald, of the Massachusetts State Reformatory; *Insanity from the Laboratory Point of View,* by Dr. John R. Harding, of the New York State Reformatory; *The Psychiatrist and the Prisoner,* by Dr. Herman Adler, State Criminologist, Springfield, Ill.; *Drug Addicts,* by James A. Hamilton, Commissioner, Department of Correction, New York.

The Prison Physicians' section appointed the following committee to map out a program for a state policy toward "defective delinquents": Dr. V. V. Anderson, Chairman; Dr. Guy G. Fernald, and Dr. John R. Harding. This committee is to make a report to the Prison Congress next year.

Society for the Promotion of Occupational Therapy

The third annual meeting of the National Society for the Promotion of Occupational Therapy was held in Chicago, September 8-11. The following officers were elected to serve for the coming year: President, Mrs. Eleanor Clarke Slagle, of the Henry Favill School of Occupations of the Illinois Society for Mental Hygiene, Chicago; Vice Presi-

dent, Dr. Herbert J. Hall, Devereux Mansion, Marblehead, Massachusetts; Treasurer, Miss Marion R. Taber, 348 Lexington Avenue, New York City; Secretary, Mr. Louis J. Haas, Bloomingdale Hospital, White Plains, New York. Chairmen of Committees elected were Mr. Thomas Kidner, Research and Efficiency; Miss Elsey Taft, of Walter Reed Hospital, Teaching Methods; Mrs. E. C. Slagle, Installations and Advice; Dr. W. R. Dunton, Jr., Finance, Publicity, and Publications; Miss Susan C. Johnson, Admissions and Positions.

Courses in Occupational Therapy at Teachers College

Teachers College, Columbia University, is offering this winter a number of courses in occupational therapy, under the direction of the Department of Nursing and Health. These include courses in methods of teaching occupations in hospitals, in practice teaching, in the industrial arts—weaving, basketry, clay modeling and pottery, etc.—in corrective gymnastics, personal and general hygiene, and mental hygiene. A program will be arranged for each student on the basis of her former preparation and experience. Those who have had no previous preparation will need at least one and a half academic years (forty-five weeks) of study in technical and educational subjects and three months of practical experience in hospitals to fit them for service in this field.

There are two general types of positions open. In the large hospitals where there are several occupational-therapy workers and where the patients are suffering from purely physical disabilities, there is a demand for teachers who are specialists in one particular line, such as drawing and designing, weaving, clay modeling, etc., while small hospitals that employ only one worker, and especially hospitals for nervous and mental cases, require a worker who has a fair command of a number of crafts and who is able to handle a wide variety of patients.

The college does not promise to find positions for students, but those who show practical ability in the teaching of patients will be directed to fields of service in connection with civil hospitals and in public and private homes and sanitaria.

The spring session begins on February 4, 1920. For a detailed description of courses or any further information, apply to the Secretary of Teachers College.

A Juvenile Paretic and His Family

Readers of Mental Hygiene who were interested in the article by Dr. Harry C. Solomon and Maida H. Solomon, *The Family of the Neuro-Syphilitic,* published in January, 1918, will be interested in the

following account of a juvenile paretic and his family, furnished by Dr. Edward Livingston Hunt to the *Journal of the American Medical Association:*

"P. A. came to my service in the City Hospital, an emaciated and crippled boy of twelve. Physically, he showed pupils that were unequal, irregular, and immobile, a coated and tremulous tongue, and a coarse tremor involving the entire body. The speech was hesitating and distinctly ataxic. He was paralyzed from the waist down.

"The physical signs showed a spastic paraplegia with the reflexes all exaggerated, and loss of control of both sphincters. There were contractures of both legs, so that he lay in bed a helpless paralytic.

"Mentally, he showed marked dementia. If touched, he would scream, and if given orders, he would obey them only after considerable repetition and explanation.

"The story that the family gave was that up to about nine years of age he had been able to attend school. After that he was unable to keep up in his lessons; the teachers found him almost impossible to manage, and his schoolmates considered him irritable and uncompanionable. He was taken out of school, but the family found him too great a care at home, and he was sent to the hospital.

"The laboratory reported a markedly positive Wassermann reaction in both the blood and the spinal fluid. In the latter the cells numbered twenty. The butyric acid test was positive, and the colloidal gold test revealed a typical paretic curve.

"The case was diagnosed as one of juvenile paresis. The young patient is still in the hospital, slowly losing both physically and mentally.

"The intern staff took considerable interest in a fourteen-year-old brother of the patient who came to see him. They induced him to allow them to take some blood for a Wassermann test. The laboratory reported this as being markedly positive.

"It then developed that there was still a third boy, aged ten. After a time we succeeded in getting a specimen of his blood. The Wassermann test on this boy was like that of his brother, markedly positive.

"The boys were sometimes accompanied by a little sister of eight. Her blood was then examined. The report showed a strong positive Wassermann reaction.

"The parents of the children were next approached with a view to obtaining a blood test. The father absolutely declined; the mother consented. The Wassermann report in her case was positive.

"Here, then, is a family of six, in five of whom the Wassermann blood test was markedly positive, and one of whom presented a typical case of juvenile paresis."

ABSTRACTS

PSYCHIATRIC CLASSIFICATION IN PRISON. By Hon. Lewis F. Pilcher, State Architect, New York. *Publication No. 53, National Committee on Prisons and Prison Labor.* New York, 1919. 6 p.

Commercial efficiency is determined by the use of the by-products of manufacture. Prisoners are by-products of society.

The modern enterprise that used to discard as waste the by-products of its plant now aims to reduce its overhead and better its system by returning to the community in usable form that which in past times had been considered as lost and unavailable material. Is it not true that the criminal has been for the most part considered in the past as an irreclaimable waste of society, his progress toward a better life inhibited by being held in the strait-jacket of strictly materialistic institutional management and maintenance? As in the case of manufacturing concerns so in the modern penal system, its success will be determined by economic use and measured, not by the development of model prisoners enchained securely behind bastioned walls, but by returning to society decent citizens.

In the past the achievement of positive human results has been seemingly impossible to obtain. The chief reason for this failure was due to the inevitable clash between institutional and political interests that always arose and rendered abortive the many attempts that have been made to treat successfully the complex questions of crime and punishment.

Any betterment procedure must be in the direction of individualization. The modern prison, penitentiary, jail, and reformatory should embody in their respective organizations the function of scientific study of the individual prisoner—and this should be made the fundamental element of the entire correctional process.

The dynamic unit of all human problems is the individual. Modern medical science makes the appraisal of this unit possible through the medium of psychiatric treatment and social service research. An undertaking, however, which is really consciously intent on reclaiming the individual prisoner to the limit of his capacity, with a view to preventing future returning to misbehavior, would be hampered in its effect if it were to concern itself solely with the native endowments of the individual prisoner. The source of the prisoner's particular being, life, is a dynamic process; and every contact the individual makes throughout life not only leaves its impression on him, but shapes his mental attitude toward his environment. Thus it is obvi-

ous that the housing problem, touching as it does every phase of the life of man, is of fundamental importance, for the environment, determining, through the influence of the associative imagery of the inmate, a control of his conscious act and the mechanization of the conscious acts of the prisoner, establishes his habits. The manner in which the prisoner has been handled in the past has unquestionably been responsible, if not for the great amount of criminal careers, certainly for the confirming of the individual in his life of crime. The character and kind of prison we have had in the past had as its sole aim to impress with medieval security, a housing condition crude and archaic in conception, which has not helped to relieve and protect society against the spirit of crime, but on the contrary has actually tended to its increase.

Here in New York City the municipality protects the interests of its citizens by the enactment of a structural and sanitary code. Structural safety and physical security and health are provided for all classifications of human activities under the maturely established provisions of the code.

Scientifically, psychologically, and practically important as is the structural side of this great prison problem, I have yet to see any workmanlike attempt to establish for prison planners a code so carefully developed and yet with an elasticity to adapt it to various localities and climates, to the end that the inhumanity of the present day, 1919, towards prisoners would be for all time impossible.

The tremendous security and help that such a code would provide for the development of state prisons and jails and reformatories is at once apparent.

The complete findings of a competent code committee would be the average of the experience of all penal housing problems throughout the country and should be determined by a two-group committee, acting under an organization of national scope, in one group of which should be available the experience and suggestion of the leaders in penal administration, medicine, psychiatric, industrial, vocational, educational, and religious activities. The second group should consist of a small number of architects, engineers, or contractual experts—men who have actually planned and structurally executed prison buildings and whose practical experience would enable them sympathetically to translate into constructive form and crystallize the theoretical standards recommended by the subcommittee on strictly scientific phases.

SING SING CLASSIFICATION PRISON

As it is an admitted fact that apperception and interest are the cardinal principles of thought foundation, it may be seen that the chance of improvement in the prisoner will vary in accordance with

the thought and action required of him. In order, therefore, that this idea may be efficiently carried out, the prisoner, immediately on commitment to prison, should receive the benefit of an expert clinical examination to determine through his mental and economical possibilities what branch of work he should follow during his term of imprisonment, to insure a betterment of existence and a chance to live a decent and productive life after discharge.

The new Sing Sing, therefore, has been planned as a classification and distributing prison, from which the prisoner, after a definite determination has been made of his mental, physical, and economic possibilities, will be assigned to that state institution best suited to his individual demands. For example, if it be found that a prisoner is physically unsound, he will be sent to an institution where he can be therapeutically bettered; or if mentally deficient, to an institution where he can be scientifically treated, and, if possible, given work that will enable him to direct his minimal capacity so as to exempt him from purely custodial care.

The construction and location of the buildings at Sing Sing means much more, therefore, than the mere erection of a series of large prison buildings for the detention of those who have violated the laws of the state. It will exist as a twentieth-century prison elixir, which will take the recrement of society and so purge and refine it that the result will advance, rather than retard, the onward and upward movement of humanity.

In order fully to understand the problem of prison registration, let us follow the course taken by the convict upon his arrival at the Sing Sing of the future. Immediately upon entering the prison grounds, the court officer conducts him to the arrival room in the basement of the Registration Building. Here he is turned over to the prison authorities, who take, and give a receipt for, his personal property and clothes. The civilian clothes are removed for disinfection and storage. He is then led to the baths, situated across the hall from the property room. After being thoroughly bathed and subjected to a hasty medical inspection, clean prison clothes are provided. Then, contagion from outside sources having been removed, the prisoner is lodged in a classification cell on the first floor, to await his turn for examination in the rooms provided for that purpose on the second floor. When the examiner is ready for him, he is taken upstairs to be photographed, weighed, finger-printed, and generally Bertillioned, and is then sent across the hall to be given a preliminary examination for the determination of his general physical condition. This over, he is led to the educational examination room, where facts concerning his birth, occupation, and general history are recorded, and an examination is conducted to determine both the extent of his

education and his occupational skill. Following that comes a careful mental examination in which the findings of those just preceding are fully utilized. As a result of these different examinations, his first classification is made, subject, of course, to change from examinations to be conducted later.

Besides containing the general Administration Offices, the Bureau of Registration, and the Record Bureau, the Registration Building will include a reception room where prisoners may converse with visiting relatives and friends. In the past this problem of a reception room for the visitors to prisoners was a difficult one for prison authorities, as it was practically impossible, while allowing prisoners a reasonable amount of freedom for the discussion of private and confidential matters, to prevent the transfer of weapons, liquors, drugs, and implements of escape. This difficulty, however, we think has now been successfully solved through the following arrangement: Two parts of a large room are separated by two wire nettings, so placed that they form an enclosed passage six feet in width, where guards can be stationed to prevent any attempt to pass articles to the prisoners without, at the same time, interfering in the carrying on of a conversation.

Adjacent to the Registration Building, and on the same high plateau overlooking the Hudson, is the Temporary Detention Building, with cell rooms on separate floors, so arranged as to place the prisoners under the constant supervision of the clinical experts, who will conduct their examinations in the adjoining Clinic Building.

The clinical laboratory was developed under a medical commission composed of: Dr. Walter B. James, President of the New York Academy of Medicine; Dr. Charles W. Pilgrim, Chairman, New York State Hospital Commission; Dr. Thomas W. Salmon, Medical Director of the National Committee for Mental Hygiene; Dr. G. H. Kirby, Director of the Psychiatric Institute of the State of New York; Dr. Isham G. Harris, Superintendent of the Brooklyn State Hospital; Dr. Carlos F. MacDonald, Alienist; and Dr. W. F. Brewer, Surgeon. Provision has been made on the first floor for a modern X-ray apparatus and its various accessories; three rooms for the physician in charge of the venereal examinations; a surgical laboratory; rooms fitted for the examinations of the eye, ear, and throat; psychiatric and psychological examining room, dental operating room and laboratory, and a laboratory for the use of the staff working in the diagnosis and examination rooms.

On the second floor is a quantitative and qualitative laboratory, a museum, a recording room, a library and lecture rooms, and on the third floor are surgical wards, subdivided for major and minor operative cases, together with medical wards, so planned as to have ordinary

and chronic medical cases in separate divisions. The hospital is to be freely used for detailed observation as well as for treatment.

The fourth floor contains a complete operating department with two operating rooms, one for major and the other for minor operations, each having separate sterilization facilities, together with preparation, etherizing, and recovery rooms, while the remainder of the floor is given up to rooms for the male nurses and a convalescent solarium.

In addition to using the building as a clinical hospital for the housing of psychiatric and medical requirements of the prison, it is also planned to use it as a school for the education of male nurses, as it is found that efficiency in prison nursing is directly proportional to the nurse's understanding of the relation of scientific, medical, and psychiatric knowledge to the peculiar problems of a prison community.

To the rear of the plateau, and connected by exterior cell block buildings with the structures just considered, two housing groups have been planned and constructed in accordance with the interlocking dormitory-cell-room type, each having accommodations for three hundred prisoners.

In the past the failure of all dormitory systems has been due to the fact that no provisions were ever made for what is technically known as "day-room space," which is as necessary in prisons as in hospitals for the insane or in charitable institutions. In the new Classification Prison a day-room-space system has been arranged for by which each prisoner is allowed fifty square feet of sleeping space in the dormitory and fifty square feet of space in the day room. Individual lockers will be provided for each prisoner, as it has been determined through former experiments that a sense of individual responsibility is evoked if each prisoner be provided with a separate locker for the safekeeping of such possessions as he may be allowed to have during his incarceration.

Experiments to determine the most efficient method of guarding dormitory prisoners have demonstrated the impossibility of a guard stationed on the main floor of a dormitory overseeing all parts of the room. To correct this difficulty, an elevated mezzanine guard walk has been planned situated eight feet above the floor proper and permitting an unobstructed view of all portions of the dormitory.

The study and practice of mob psychology have demonstrated that when a group of fifty men are continually together, there arises an inner controlling group, numbering from seven to eight men, this number decreasing in irregular steps down to the one man who dominates a group of from ten to twelve. Using this fact as a basis for further experiments, it was decided that a mean between these two

numbers (twenty-seven) resulted in the most satisfactory group arrangements, and the dormitory units have been designed accordingly.

The interlocking dormitory-cell-room buildings provide the elasticity of classification demanded by the more advanced penological ideals. Each dormitory building will be three stories in height and will have two dormitory units, symmetrically placed on each floor, each unit consisting of a day room, lavatory, locker room, and dormitory proper. Access to the dormitory floor is by a central stairway, while the cell-room floors are reached from intermediate landings in the main stairway.

The entire Sing Sing project includes kitchens, dining rooms, library, school, vocational shops, recreation hall, roads, walks, a modern sewage plant, a power house to heat and light the many buildings and to operate the industrial plants, and a church for the development of religious and community ideals.

In addition to the proper placing and coördination of the structures and their component parts, and the abolishment of unsanitary conditions in the interiors, by the architectural treatment of buildings and site, a great step forward has been taken in the creating of a proper and fitting atmosphere and environment. The old idea of the ugly, heavy barred and broken walls, which produced the dismal, forsaken, isolated, and jaillike appearance of former prisons, has been discarded. In their places will be many-windowed, substantial brick structures, extending from the river to the plateau in the rear of the elevated site, in dignified and well-proportioned stages.

The causes which formerly created in prisoners the feeling of being entombed, useless and hopeless exiles, have been done away with. It is our hope that ideals of respectability, industry, efficiency, and coöperation will arise from these new prison conditions and make strong, beneficial, and lasting impressions on the mind of each prisoner.

Sex, Age and Nativity of Dementia Praecox First Admissions to the New York State Hospitals 1912 to 1918. By Horatio M. Pollock and William J. Nolan. *The State Hospital Quarterly*, 4:498-516, August, 1919.

This study deals with 9,124 resident dementia-praecox first admissions admitted to the civil state hospitals of New York from October 1, 1911 to June 30, 1918. The period covered comprises 6¾ years.

Of the 9,124 patients studied, 4,762 were males and 4,362 females. The percentages were 52.2 and 47.8 respectively. The 1915 census of the state does not give the sex distribution of the general population, but in the state in 1910, according to the federal census, there were 101.2 males to 100 females; among the dementia-praecox first admissions of 1912 to 1918 there were 109.2 males to 100 females.

Unless the sex distribution of the population of the state has changed materially since 1910, the general rate of incidence of dementia-praecox is considerably higher among males than among females. A comparison of sex distribution by age periods throws additional light on the matter. Only 8 males and 11 female patients were under 15 years of age at the time of admission.

TABLE 1. COMPARISON OF SEX OF DEMENTIA-PRAECOX FIRST ADMISSIONS WITH THAT OF GENERAL POPULATION

Age periods	Number of males to each 100 females	
	Dementia-praecox first admission	General population of state 1910
15 to 19 years	159.3	94.3
20 to 24 years	180.3	96.1
25 to 29 years	143.3	105.0
30 to 34 years	114.5	107.0
35 to 39 years	78.7	105.4
40 to 44 years	58.4	107.4
45 to 49 years	45.8	105.7
50 to 54 years	32.3	105.5
55 to 59 years	40.4	101.6
Over 60 years	47.2	90.1

The variations in the distribution of patients of the two sexes in the several age groups are quite striking and indicate that sex is a factor that must be reckoned with in considering the causation of the disorder. Between the ages of 15 and 35 years, the rate of incidence is higher among males than among females; above the age of 35, the rate is higher among females. The rates of admission for the whole period per 100,000 of population in the several age groups based on the data of the 1910 census were as follows:

TABLE 2. RATES OF FIRST ADMISSION OF DEMENTIA-PRAECOX PATIENTS FROM 1912 TO 1918 PER 100,000 OF GENERAL POPULATION

	Number			Per 100,000 of general population		
	Males	Females	Total	Males	Females	Total
15 to 19 years	446	286	732	107.6	64.5	85.4
20 to 24 years	1,179	654	1,833	256.3	136.5	195.2
25 to 29 years	1,195	834	2,029	265.2	194.3	230.6
30 to 34 years	811	708	1,519	204.3	190.7	197.7
35 to 39 years	543	690	1,233	148.6	199.0	173.1
40 to 44 years	282	483	765	90.8	167.0	127.5
45 to 49 years	151	330	481	58.3	134.8	95.5
50 to 54 years	65	201	266	30.3	98.7	63.6
55 to 59 years	38	94	132	25.6	64.4	44.9
60 years and over	25	53	78	8.0	15.4	11.9
Total	4,735	4,333	9,068	103.9	96.3	100.1

The highest rate of admission among the males, 265.2, is found in the age group 25 to 29 years; the highest rate among females, 199.0, occurs in the age group 35 to 39 years. The rate among the males declines very rapidly after age 35 is reached, while the rate among the females declines quite gradually beyond the age of 40 years. In the age group 50 to 54 years, the rate among the females is three times as high as among the males.

Dementia praecox is often referred to as adolescent mental disease. That such characterization is not warranted is evident from the foregoing rates and from the following comparison of the per-cent distribution by age groups of the dementia-praecox patients and the general population.

TABLE 3. PER CENT DISTRIBUTION BY AGE GROUPS OF THE DEMENTIA-PRAECOX FIRST ADMISSIONS AND OF THE GENERAL POPULATION OF THE STATE

Age groups	Dementia praecox			General population		
	Males	Females	Total	Males	Females	Total
Under 15 years....	0.1	0.3	0.2	27.3	27.3	27.3
15 to 19 years....	9.2	6.3	7.8	8.9	9.6	9.2
20 to 24 years....	24.8	15.0	20.1	10.0	10.6	10.3
25 to 29 years....	25.1	19.2	22.2	9.8	9.5	9.7
30 to 34 years....	17.0	16.3	16.6	8.7	8.2	8.4
35 to 39 years....	11.4	15.8	13.5	8.0	7.7	7.8
40 to 44 years....	5.9	11.1	8.4	6.8	6.4	6.6
45 to 49 years....	3.2	7.6	5.3	5.6	5.4	5.5
50 to 54 years....	1 4	4.6	2.9	4.7	4.5	4.6
55 to 59 years....	0.8	2.1	1.4	3.2	3.2	3.2
60 years and over	0.5	1.2	0.9	6.8	7.6	7.2
Unascertained	0.6	0.6	0.6	0.2	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

NATIVITY, SEX, AND AGE

Of the 9,124 dementia-praecox first admissions, 4,690, or 51.4 per cent, were native; and 4,405, or 48.3 per cent, foreign born. The nativity of 29, or 0.3 per cent, was unascertained. The percentage of foreign-born in the general population of the state in 1910 was 29.9.

The sex distribution of the native and foreign-born dementia-praecox first admissions was as follows:

	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Native	2,445	2,245	4,690	51.3	51.5	51.4
Foreign-born	2,297	2,108	4,405	48.2	48.3	48.3
Unascertained . ..	20	9	29	0.4	0.2	0.3
Total	4,762	4,362	9,124	100.0	100.0	100.0

It is noteworthy that the percentage of foreign-born among the males is practically the same as that among the females.

The foreign-born dementia-praecox first admissions have come principally from Austria, Germany, Hungary, Ireland, Italy, and Russia, although nearly all the nationalities of the world are represented in the group.

The patients coming from the six countries above named and from all other foreign countries were distributed as follows:

	Number			Per cent of total cases		
	Males	Females	Total	Males	Females	Total
Austria	290	308	598	6.1	7.1	6.6
Germany	214	274	488	4.5	6.3	5.3
Hungary	109	131	240	2.3	3.0	2.6
Ireland	166	362	528	3.5	8.3	5.8
Italy	329	199	528	6.9	4.6	5.8
Russia	549	337	886	11.5	7.7	9.7
All other foreign countries	640	497	1,137	13.4	11.4	12.5
Total foreign-born	2,297	2,108	4.405	48.2	48.3	48.3

Among the Irish dementia-praecox patients, the females outnumber the males by more than two to one, while among the Italians and Russians the males are largely in excess of the females.

COMPARISON OF RATES OF ADMISSION AMONG NATIVES AND FOREIGN-BORN

Through the courtesy of the Federal Census Bureau in furnishing us with photostat copies of the distribution of the general population of the state in 1910 by nativity, sex, and age groups, we are able for the first time to compute comparative rates of admission of dementia-praecox first admissions for each of the several divisions of the population. While the data of the 1910 census cannot be considered entirely satisfactory as a basis for the computation of either absolute or comparative rates, it is the only basis available at the present time.

The following tables show the rates of dementia-praecox first admissions to the civil state hospitals during the years 1912-1918, classified by nativity and age per 100,000 of the general population of the state in 1910 of the same nativity and age.

TABLE 4. DEMENTIA-PRAECOX FIRST ADMISSIONS BORN IN THE UNITED STATES

Age group	Number			Rate per 100,000 in general population of same nativity and age		
	Males	Females	Total	Males	Females	Total
Under 15 years.....	3	5	8	0.3	0.4	0.4
15 to 19 years.....	280	181	461	87.7	54.9	71.0
20 to 24 years.....	670	326	996	242.3	109.0	173.1
25 to 29 years.....	570	405	975	239.6	161.3	199.4
30 to 34 years.....	387	379	766	183.0	168.8	176.2
35 to 39 years.....	249	355	604	125.2	172.0	149.0
40 to 44 years.....	139	236	375	84.1	138.8	111.8
45 to 49 years.....	71	172	243	50.8	119.2	85.6
50 to 54 years.....	33	96	129	26.8	77.1	52.1
55 to 59 years.....	17	51	68	19.7	58.5	39.2
60 years and over	19	27	46	11.0	13.9	12.6
Total	2,445	2,245	4,690	79.4	71.1	75.2

The general average rate of dementia-praecox first admissions for the whole period of 6¾ years among the native population was 75.2 per 100,000. Among the native males the rate was 79.4 and among the native females, 71.1. Among the males the highest rate, 242.3, is found in the age group 20-24 years. The highest rate among the females, 172.0, is found in the age group 35-39 years.

TABLE 5. DEMENTIA-PRAECOX FIRST ADMISSIONS BORN IN FOREIGN COUNTRIES

Age group	Number			Rate per 100,000 in general population of same nativity and age		
	Males	Females	Total	Males	Females	Total
Under 15 years.....	4	6	10	4.2	5.3	4.7
15 to 19 years.....	159	94	253	183.8	91.0	134.2
20 to 24 years.....	506	328	834	289.1	193.1	241.8
25 to 29 years.....	622	424	1,046	308.0	254.0	283.6
30 to 34 years.....	420	329	749	238.1	235.5	237.0
35 to 39 years.....	292	332	624	184.5	249.1	214.1
40 to 44 years.....	139	246	358	99.7	214.6	151.5
45 to 49 years.....	80	158	238	69.6	163.2	112.4
50 to 54 years.....	32	105	137	36.1	137.4	83.0
55 to 59 years.....	21	43	64	35.0	75.2	54.6
60 years and over	6	26	32	4.4	17.5	11.3
Total	2,297	2,108	4,405	160.4	162.5	161.4

The general average rate of dementia-praecox first admissions for the whole period among the foreign-born population of the state was 161.4. Among the foreign-born males the rate was 160.4, and among

the foreign-born females, 162.5. It will be noted that these rates are more than twice as high as those among the native population. The highest rate among the foreign-born males, 308.0, occurs in the age group 25-29 years. The highest rate among the foreign-born females, 254.0, is found in the same age group. Among both the native and foreign-born there is a higher rate among males than among females in the age groups up to 35 years. Beyond that period there is a higher rate among females.

CONCLUSIONS

1. The general rate of first admissions of dementia-praecox patients in New York State is higher among males than among females.

2. The rates among males are much higher than those among females in the age groups under 35 years; the rates among females are higher in the age groups above 35 years.

3. The highest rate among males is found in the age group 25 to 29 years; among females in the age group 35 to 39 years.

4. The rate among the foreign-born is higher than among the native population in both sexes and in each age group up to 60 years.

5. The foreign-born dementia-praecox first admissions have come principally from Austria, Germany, Hungary, Ireland, Italy, and Russia.

6. Wide differences are found in the rates of dementia-praecox first admissions in the several nationalities, the lowest rates being among the native population and the highest among the Austrians and Hungarians.

7. There is a much higher rate of dementia-praecox first admissions among Irish females than among Irish males.

THE CYCLE OF REVOLUTION. By Alfred B. Kuttner. *The New Republic*, 20:86-88, August 20, 1919.

* * * The revolutionary cycle may be stated somewhat baldly as follows. It begins with a sudden eruptive release of the inhibitions surrounding law and order and property, in the form of a seizure of state authority and of such commodities as food and arms. From there it rapidly proceeds to the abolition of all inhibitions in practically every sphere of public and private life. When this has been accomplished, the revolution reaches its summit and then for a time remains stationary. The turn comes when a new set of inhibitions appear which gradually find general acceptance in place of the old ones. Society has then been reconstituted. For society rests upon inhibitions, whereas the absence of inhibitions means either revolution or the savagery which antedates all known forms of society.

Revolution is the only savagery of which we have first-hand knowledge.

Revolutions are usually preceded by demands for reform—land and tax reforms in the French Revolution, administrative and land reforms in Russia, and electoral reforms in Germany—which are of so mild a nature that they commend themselves even to the most conservative and would seem to contain no cause for alarm. They represent what is really a false front and conceal the true revolution behind what is apparently a mere reform movement. The real revolution can be detected only by a certain undertone which runs through the affected classes. This undertone expresses itself in the voicing of a number of high-sounding ideals of a general humanitarian nature, together with certain religious and millennial ideas. These are quite disproportionate to the specific reforms proposed and really have very little to do with them. Yet it is by studying these ideals that we learn the nature of the inhibitions under which society has been chafing and which it is now about to throw off.

For it must be borne in mind that an ideal, psychologically considered, is a state in which we are able to release a group of inhibitions without regard for our realistic environment. In the ideal of paradise, for instance, we think of ourselves as going about naked because we have been relieved of the inhibitions of shame and of sex, we solve the problem of food without exerting ourselves, and we feel freed from all evil impulses because impulses are felt to be good or evil only in relation to inhibitions, all of which, fortunately, we have left behind us on earth. Our ideals always bear a direct relation to our deepest suppressions, a fact which goes far in explaining why ideals have a way of being the preliminaries to brutalities.

As we follow the successive steps of a revolution, one of the first things which strikes us is that the radicals who are in being at the time almost immediately experience a conservative reaction. They want to put the brakes on the revolution as soon as their cherished reforms have been put into effect. They utterly fail to grasp that these reforms which hitherto have encountered the resistance of society are successfully put through now only because they are carried by the wave of a social convulsion which scorns all checks. These radicals represent a momentary stability of society because they are inhibited by the logic and the limitations of their goal, whereas the revolution knows no logic and acknowledges no limitations. They are unable to maintain themselves upon the quicksand which they vainly try to tread; they cannot, so to speak, step upon blood without slipping, which is a very poor thing for revolutionists to do. In short they become a kind of new middle class and their reaction would teach us, if history had not already done so, that revolution never springs

from the middle classes, the so-called bourgeoisie. What at most the middle classes can achieve, as in 1848, is a reform movement attended with a certain amount of violence. They have too many vested interest to want a radical subversion of the existing government. They do not seek to abolish and usurp authority directly, but merely to present demands to it. It is a condition of their activity to keep the government in being, for they feel the threat of a lower and much more unstable stratum of society which is peculiarly susceptible to the contagion of violence.

As soon as these former radicals have been discredited, the revolution sharply increases its pace and plainly becomes a progressive release of all restraints and inhibitions. The formula is simple. Any existing leader or group of leaders can be overthrown by those who propose some still more radical measure which promises a further release of inhibitions. The leaders in being must either acquiesce and thereby share and really lose their leadership, or else they must assume a conservative position and thus become exposed to the resentment of the mob, which execrates them as the embodiment of those restraints which the mob is bent upon casting off. In revolution the mob is always the court of last appeal, and, little though we know about mob psychology, it is a matter of common observation that the mob is chronically inclined to prefer a radical proposal to a conservative one. To tell the mob to restrain itself and do nothing is equivalent to asking it to disperse, and the astute leader knows that he can always form a new cohesion and impart fresh impetus to the mob by inciting it to further destructive action. The counsel of restraint can always be trumped by the counsel of excess. Thus the opening phases of revolution always present the spectacle of many rapid shifts of leadership with a progressive disorganization of the whole structure of existing society.

The more theoretical developments of revolution keep pace with these political upheavals. Thus new theories of religion and of sexual relations seem to be an integral part of all revolutionary movements. This is not at all surprising if we bear in mind that religion and some kind of sex code are among the earliest social forms in which psychic inhibitions express themselves. The new forms which now take their place are characterized by a minimum of inhibitions; the religion of revolution is an ideal religion, that is, a religion without retribution, while the new sex code avoids the consequences of cohabitation or at least shifts them from the individual to society as a whole. Both these developments run parallel to the revolutionary economic theory in which toil is eliminated or ideally converted into play.

Yet it is entirely to the credit of revolution that man's deepest inhibition, the inhibition against killing, maintains itself longest. Revo-

lutionary movements are always imbued with a spirit of altruism and universal brotherhood, the sincerity and depth of which it would be very unjust to doubt. Capital punishment is abolished and a general amnesty is granted, as if the revolution were striving by every means in its power to contrast itself with the tyranny against which it was invoked. Indeed, one of the most precious contributions of revolutions is this new sense of the value of the individual. But as revolution necessarily encounters resistance from without and differences from within, a subtle transformation takes place which is further helped by the contagion to which the inhibition against killing is exposed by the general breakdown of inhibitions in every other sphere. The value of the individual begins to recede again in proportion as the ideals of the revolution are threatened. When these ideals become so exalted in the minds of the revolutionists that human life seems worthless by comparison, the inhibition against killing is finally swept away. History teaches us, not only through revolutions, but through such things as the Crusaders, the Inquisition, and all "holy" wars, that humanity is usually at its worst when it begins to slay for the sake of an ideal.

The plea that revolutions would be idyllic if they were only left alone is beside the point. Short of a simultaneous world-wide revolution, they will never be left alone. Every still civilized—that is, inhibited—community in contact with revolution will resist it. To approve it would be to acquiesce in it, would mean to consent to a similar release of all inhibitions. Such a release is always contagious and it is to guard against this contagion that these communities pour out their wrath and condemnation. Their action is comprehensible, even though they resort to every form of misrepresentation; it is certainly notable that the sympathy which any revolution may arouse usually comes from communities sufficiently far removed to be safe from the revolutionary contagion. What is perhaps more unreasonable is the extreme horror which revolutionary excesses evoke; for, after all, revolutions merely do in a concentrated way things which are often condoned by the historian as long as they are thinly spread over a century or two.* A bloodless revolution is really a contradiction in terms; real revolution always penetrates down to the deepest strata of inhibitions and must therefore necessarily arouse the fiercest resistance. In a society sufficiently elastic to accommodate itself without friction to such changes a revolutionary movement could never gain headway in the first place.

The revolutionary cycle as we have followed it thus far has now arrived at the stage where the revolution is "wide open;" the lid is off

* Compare the reply of the Bolshevik government to the protest of the Allies against the alleged revolutionary excesses in Russia.

the millennium. But the end is now also at hand. When revolutions have once reached the orgiastic stage, they quickly run down. The French Revolution literally exhausted its ingenuity for killing. The emotional labor involved in the release of inhibitions absorbs all available energy and finally produces a state very much akin to boredom. The ultimate revolutionist may be described as a man who goes about naked, wolfs his food, appropriates anything he covets, possesses every woman that strikes his fancy, and slays without hesitation. He is the completely uninhibited man. As such, however, he is quite unstable. Man as we know him seems to be incapable of ridding himself of an inhibition without immediately setting up another inhibition in its place. Just as the old society was destroyed by the release of inhibitions, the new society can be only restored by establishing new inhibitions.

This constructive process has really been operative since the beginning of the revolutionary movement. The revolutionist policy of living from hand to mouth economically, combined with the constant threat from without, gradually forces the current of thought out of its ideal setting back into contact with the actualities. The purely circular movement of uninhibited impulses is replaced by directed thinking working towards a realistic goal. A new attitude towards law, property, religion, and sex becomes expressed in a new series of inhibitions which spring up at the periphery and slowly work towards the center of the revolution. It is the beginning of a compromise which, from a theoretical point of view, has many reactionary aspects, if only because in practice it is always supported by the aristocrats, capitalists, militarists, ecclesiasts, and what not, whom the revolution has driven out. But it is justified and gathers its strength as a function of the fundamental compromise between impulse and restraint which underlies all society. The revolution, despite itself, contributes to it, due to a man's inveterate habit of setting up a new inhibition in place of the one he rejects, upon which we have already commented, as when he repudiates a religion only to proclaim a new one, or abolishes marriage only to conform to a new sexual code which merely does not go by the name of marriage. In proportion as the revolution slows up at the center, these new inhibitions bear down upon it until they finally overtake and destroy the ultimate revolutionist, much as hounds freshly thrown into the pack at last pull down the stag. This last phase of the revolution is really an act of social vengeance against the transgressors of inhibitions which are now again felt to be holy. * * *

BOOK REVIEWS

Outlines of Psychiatry. By William A. White, M.D. Washington: Nervous and Mental Disease Publishing Company, 1918. 319 pp. (Nervous and Mental Disease Monograph Series No. 1, Sixth Edition.)

The appearance of a new edition of this most excellent book will be welcomed by all who are students and teachers of psychiatry and by those who wish to consult a book that is modern in its viewpoint and clear and systematic in its method of presentation.

The biological viewpoint that the author maintains towards neuropsychiatric disorders is one that is in harmony with the present trends of psychiatry and one that peculiarly adapts the book for use as a medical textbook. The breadth of interest that such a viewpoint gives to the subject of psychiatry is stimulating and permits the utilization of a large amount of data drawn from quite varied fields of research. Much of such material is introduced in the discussions of the various clinical groups.

The first chapter of the book is a psychological introduction that lays the groundwork for the viewpoint that is developed in the next chapter, which deals with the nature of mental disorders. The keynote of this chapter is the theory that mental disorders are due to failure of adaptation of the individual to the requirements of his environment: "A psychosis is the expression on the part of the individual of his type of reaction to the environment;" "The individual reacts to his milieu by the development of mechanisms that may include as parts the crass physical at one end and the refined psychic at the other." Whatever produces inadequate functioning of either may bring about failure.

There follow four chapters devoted respectively to the classification, causes, treatment, and general symptomatology of mental disorders. The chapter on treatment gives practical descriptions of the technique of hydrotherapy, methods of dealing with the refusal of food, and the use of medicinal agents. Several pages are devoted to the practical application of psychoanalysis. The general symptomatology of mental disorders is covered in a chapter of thirty-three pages. This is a presentation of the abnormal manifestations of the psychoses, considered as they involve various psychological fields and illustrated by examples given in brief abstracts from clinical histories.

Eleven chapters are devoted to the clinical types of the psychoses

and to the border-line and episodic states. In his classification the author follows the clinical grouping that is to-day in general use in American psychiatry. The discussion of the separate groups is carried through in a systematic arrangement, with the introduction of numerous references to the literature of the subject and brief discussions of special viewpoints. The concluding three chapters are devoted to the technique of mental examinations. One of these gives a model for a minimum mental examination that should be helpful in the organization of systematic methods of study. The inclusion of a chapter devoted to the technique of the Binet-Simon scale for intelligence testing adds much to the convenience of the book.

Like all of the publications of the series of Nervous and Mental Disease monographs, the book is excellently printed. Altogether, it is perhaps the most useful textbook of psychiatry for the medical student that has as yet been issued in this country.

ALBERT M. BARRETT.

THE EDUCATION OF HENRY ADAMS. By Henry Adams. Boston: Houghton Mifflin Company, 1918. 519 p.

To the psychoanalyst, Henry Adams' story of his life as a continuous search for education presents a rich field. In the light of his own account of his family background and childhood experiences, the factors that shaped every momentous decision of his later life become clear, and the reasons for his utter lack of personal satisfaction in his achievements are apparent. It is interesting to review the chief events of his career from this viewpoint, and to note the psychic determinants that shaped his reactions to the vitally different conditions he was forced to meet during his lifetime.

Henry Adams was born February 16, 1838, "under the shadow of Boston State House," as he himself expresses it. The first recorded incident that was to have a direct bearing upon his whole life was the severe case of scarlet fever which developed shortly before his third birthday and left him sickly and ailing for over a year afterward. Of this early sickness, Adams says:

"As a means of variation from a normal type, sickness in childhood ought to have a certain value not to be classed under any fitness or unfitness of natural selection; and especially scarlet fever affected boys seriously, both physically and in character, though they might through life puzzle themselves to decide whether it had fitted or unfitted them for success; but this fever of Henry Adams took greater and greater importance in his eyes, from the point of view of education, the longer he lived. At first the effect was physical. He fell behind his brothers two or three inches in height, and proportionally

in bone and weight. His character and processes of mind seemed to share in this fining-down process of scale. He was not good in a fight, and his nerves were more delicate than a boy's nerves ought to be. He exaggerated these weaknesses as he grew older. The habit of doubt; of distrusting his own judgment and of totally rejecting the judgment of the world; the tendency to regard every question as open; the hesitation to act except as a choice of evils; the shirking of responsibility; the love of line, form, quality; the horror of ennui; the passion for companionship and the antipathy to society—all these are well-known qualities of New England character in no way peculiar to individuals, but in this instance they seemed to be stimulated by the fever, and Henry Adams could never make up his mind whether, on the whole, the change of character was morbid or healthy, good or bad for his purpose. His brothers were the type; he was the variation." (p. 6)

Had he been an ardent student of Adler,[1] Adams could not have given a more graphic outline of the typical characteristics of the neurotic constitution. It is obvious that the attack of scarlet fever that he suffered in his infancy brought out all the latent neuroticism of his organism which was manifested in a feeling of inferiority both physical and mental, and in a sense of inability to cope with his environment. That these mental attitudes were present all the rest of his life a detailed study will show, for he never quite succeeded in attaining the full realization of the compensative will to power which alone could have relieved his psychic stress.

It was only to be expected, from the psychoanalytic standpoint, that Adams should cherish all the more lofty ambitions for the future on account of his childish inability to compete with his brothers and comrades. His Grandfather Adams unconsciously became the ideal of his future life because he was associated with the wild, free summers in the country, where every sense of the oversensitive child thrilled to a constant stream of vivid stimuli, and where for a few months of each year the neurotic boy felt a full abundance of life coursing through his veins. Thus favorably contrasted with his maternal grandfather—who was held by his business interests in the urban environment that Henry Adams knew only in the winter, which sapped his vitality and brought back the feeling of inability to meet the problems of life—John Quincy Adams, "the President," became the dominant figure of his unconscious life. Thus, at the age of ten, his ambitions were all political, and he felt no doubt that he, like his forbears, would have a controlling hand in the destiny of his country.

This certainty, which seemed warranted in the light of his family

[1] Adler, Alfred. The Neurotic Constitution. New York: Moffat, Yard, and Company, 1917.

affiliations, made the events of his real career all the more disappointing. Even when his reason told him in after years that success lay in the business world, that the old political regime was subordinated to new economic forces, this subconscious attitude held him to the old ideal; just as he had rebelled vainly against the authority of a school in the chilly winters of his boyhood, so later he fought the capitalistic system which in the lower levels of his psyche was indissolubly associated with the devitalizing atmosphere of his Grandfather Brooks' home. (p. 22) Thus prevented from following the dictates of his conscious judgment, and unable to realize his political ambitions, he spent his life in the futile attempt to find a work that would give him the feeling of power which his neurotic constitution craved. The psychological reason for his failure to attain this comforting sense of achievement lay in the unconscious complexes centering around the figure of his Grandfather Adams, which could be content only with a life and career impossible of attainment under the changed conditions of Henry Adams' mature years.

After the death of his idolized grandfather, his associations with his father only deepened the boy's political aspirations. His father was constantly involved in national affairs and when he read aloud to the family, it was always extracts from the best political speeches of the day. At the age of twelve, Henry Adams was as ardent a free-soiler as his friend and hero, Charles Sumner; yet this very fact only deepened his isolation and threw him back upon his inner resources, for his schoolmates were all pro-slavery. The passion for reform, which is characteristic of the Puritanical New England temperament, became intense in his case. The desire to be a political reformer never left his heart, but was slowly repressed by external circumstances which proved its utter hopelessness after many years of young manhood had been wasted in the attempt to attain its realization. Had Henry Adams been able to succeed in his ambition to become a political reformer, the sense of power which is concomitant with the feeling of ability to control the destiny of a nation would have been his, and his long struggle to feel himself in harmony with his environment would never have become necessary. As matters turned out, he was never able to satisfy any of the deeper longings of his unconscious life, and hence was never rid of the sense of failure in any undertaking.

In Adams' four years at Harvard there is little to interest the psychoanalyst. His extreme surprise at being elected class orator shows the persistency of his feeling of inferiority and the desire for power in order to assure himself of the groundlessness of his neurotic fears and doubts. The election was a real satisfaction because "it was political as well as literary success" and thus was in complete

harmony with his unconscious life. (p. 66) Yet there were certain doubts which crept in to mar any perfect and lasting satisfaction in the honor. Adams felt that he was in reality less capable than his defeated rival—that he had been chosen only because he mirrored the shortcomings of his comrades and hence was an acceptable representative of his class.

"All the same the choice was flattering," he remarks, and adds, with the cumulative bitterness of a disappointed life, which cannot be entirely repressed, "so flattering that it actually shocked his vanity; and would have shocked it more, if possible, had he known that it was to be the only flattery of the sort he was ever to receive." (p. 68)

In that one sentence Adams betrayed the fact that even toward the end of his life, while he was writing his autobiography, the unsatisfied political ambition was still existent, still rendering impossible any satisfaction with himself and his work, the enduring condition of his conviction of an incomplete education and his continual search for the missing instruction that would enable him to meet the exigencies of his environment.

Equally barren of events influential in his later life were the two years abroad by means of which Adams sought to complete his formal education. In 1860 he returned to Boston, there to be plunged into the political chaos that preceded the Civil War.

Finding himself unable to begin the practice of law, for which he had prepared himself, Adams helplessly resigned himself to his father's suggestion that he become his private secretary, and accompanied the Congressman to Washington. The most important happening during his year at the national capital, from the psychological viewpoint, was the loss of the friendship of his boyhood hero, Senator Sumner, on account of a political quarrel between the latter and his father. With characteristic neurotic sensitiveness, Adams concluded that it was useless to expect to retain the friendship of any one who was in power, and thereafter he acted always on that belief. Shortly after this disheartening occurrence, Charles Francis Adams was appointed Minister to England, and thither, still as private secretary, his son accompanied him.

During his English sojourn, there were many circumstances which tended to emphasize Henry Adams' sense of inability, and to intensify the longing for power. In the first place, the position of private secretary was galling to his pride both as an anticlimax to his youthful ambitions and as a barrier to the entree into society that seemed due to a descendant of his Grandfather Adams. Again, party loyalty bade him return to America and take a personal part in the Civil War, but with characteristic hesitancy he put off a decision on the plea of duty to his father until it was too late. Hence the

feeling that he had shirked his responsibilities and shown himself, if not cowardly, at least a weakling. For a free-soiler like Adams, too, there could be no peace in the presence of the English attitude, which was frankly pro-slavery, and he came to feel himself to be the center of a hostile world, possessed of no weapons of defense. It was humiliating, to say the least, to hear people at social gatherings openly rejoicing when things went badly for the Federals, and it was far from consoling to feel that he was not at home, doing his utmost in the ranks of the Unionist army.

Even his attempts to be indirectly useful met with overwhelming disaster. Being unofficially connected with the legation, yet in a position to know the inside of affairs, Adams had a vision of influencing public opinion through the press. Unfortunately, an article appeared bearing his signature, and he was immediately held up to ridicule by the *London Times*. It was well for his country's cause that the *Times* did not know of his connection with the American Legation. It is hard to say whether this emphasis of the obscurity of his position brought more relief at the harmlessness of his activities or chagrin at the realization of his own humble situation. (p. 120) Certain it is that it was balm to Adams' heart when, some time afterwards, Deland, the author of the *Times* satire, saw him receiving congratulations upon the triumph of his friends at Gettysburg. (p. 170)

And so one might go on to enumerate humiliation after humiliation which the young private secretary endured before he returned to America. There was the meeting with Swinburne, for instance, whose poetic fervor was beyond the comprehension of an unemotional young Bostonian, but whose undoubted genius, though as yet unheralded by the world, more than ever impressed him with a sense of his own defects. (p. 142) There were the little mistakes in etiquette which "made him writhe in torture" when he finally did begin to receive social recognition. (p. 118) Worst of all was the discovery, some time later, that he had grossly misinterpreted the motives and actions of those high in English political life—Gladstone, Palmerston, Granville, and other important figures. And it was little consolation to one so sure of the correctness of his estimates to learn also that they had even misinterpreted one another. (pp. 150-165)

After the ending of the Civil War and the return to America came a period of newspaper work which was as far from satisfying to Adams' aspirations as any other of his attempts to find a career. Then came the Darwinian theory of evolution, and for a time Adams sought to find solace in an attempt to Americanize its principles. But he was never able to understand any satisfactory evolutionary process in history or in his own life. Because he had failed to foresee correctly the events of his own future or of the history-making epoch

through which he had passed, he denied the possibility of any unified evolutionary tendency in the cosmos; it was less humiliating to conceive of the world as a chaotic one, insubordinate to law and causality, than to admit any more personal mistakes, when already his failures to meet and conquer life struck him in the face no matter where he turned. He abandoned Darwin, and once again sought the press. If he had failed to become a political reformer himself, he would at least find some reform movement and support it with all the literary fervor at his command.

But the world of politics had changed since the childhood days which had fashioned his unconscious ambitions. Already the era of modern invention and involved business interests was dawning, and the day of political reform, in Adams' sense of the term, was past. He had plenty of opportunity to gain an intimate knowledge of the men who were making history, but that was consoling only in so far as it revealed them to be equally weak and ignorant with himself. Thus, at least, he pictures most of them, and seems to find a certain melancholy pleasure in the reflection that if he is no better than his contemporaries, at least he is no worse. To such a point of depression have fallen the youthful dreams of a political career. The bitter recognition that he can never feel the gratifying thrill of power that comes from social control is forced home at last, and he can only find temporary relief in the assurance that his is only one of the many promising lives wrecked by the social and economic changes of his day.

It was entirely as a surprise that the invitation to accept a professorship in the Department of History at Harvard University came to him. But it was so entirely out of harmony with all his unconscious ambitious strivings for power that at first he declined the honor unequivocally, and only family pressure, from the influence of which his neurotic nature was never able to free itself, made him reverse his decision. The recognition which Adams received in the line of work that opened up to him thus unsought would have been sufficient to satisfy the ambition of any ordinary man, but it brought him less than ever of personal satisfaction. In the first place, it was so out of harmony with his repressed political ambitions that he could never find in it more than a temporary makeshift for a career. Again, the editorship of the *North American Review,* which went with his new position, proved disappointing, for he found himself now entirely without personal influence, since he had no time left for the preparation of articles himself, but must give all his leisure to the details of management. As for his history courses, he could see no unified viewpoint from which to teach them, since he was unable to offer them from an evolutionary one and was unable to evolve any coherent system of his own

to take its place. Altogether, it was a relief when he could resign his position as professor of history and drift back into his old haunts at Washington, to spend his last years watching the political game in which he had always been denied the role he craved so intensely.

To the ardent Freudian, Henry Adams' autobiography will indeed be disappointing, for it offers not the slightest proof of the sexual theory as an explanation of life. It may be that the almost entire absence of any sexual element in Adams was an inherent part of his neuroticism, and that continual repression of the sex instinct was necessitated by the constant endeavor to find an outlet for his will to power. It may be, too, if Jung's[1] exposition of the neurotic conflict as the struggle between these two motives is correct, that to this successful inhibition of any erotic impulses Adams owed his escape from the marked neuroticism that might logically be expected from an analysis of his personality. It is certain that he permitted very little emotion, except the tinge of regret from the thwarting of his power motives, to creep into his account of his life, yet there are one or two paragraphs indicative of an undercurrent of eroticism which occasionally did flow over into his conscious life.

Apart from the fixation upon his paternal grandfather as a symbol of life and power, there was perhaps one other attachment stronger than the usual neurotic clinging to the family group. This was Adams' affection for his sister, Mrs. Charles Kuhn. His first description of her reads as follows:

"Luckily for him he had a sister much brighter than he ever was—though he thought himself a rather superior person. . . . She was the first young woman he was ever intimate with—quick, sensitive, wilful, or full of will, energetic, sympathetic, and intelligent enough to supply a score of men with ideas—and he was delighted to give her the reins—to let her drive him where she would. It was his first experiment in giving the reins to a woman, and he was so much pleased with the results that he never wanted to take them back." (p. 85)

One other significant reference to this sister occurs in the account of her death:

"The sickroom itself glowed with the Italian joy of life; friends filled it; no harsh northern lights pierced the soft shadows; even the dying woman shared the sense of the Indian summer, the soft, velvet air, the humor, the courage, the sensual fulness of Nature and man. She faced death, as women mostly do, bravely and even gayly, racked slowly to unconsciousness, but yielding only to violence, as a soldier sabred in battle." (p. 288)

1 Jung. C. G. Die Psychologie der Unbewussten Prozesse. Zurich: Rascher et Cie, 1917.

"With nerves strained for the first time beyond their power of tension, he slowly traveled northward with his friends, and stopped for a few days at Ouchy to recover his balance in a new world; for the fantastic mystery of coincidences had made the world, which he thought real, mimic and reproduce the distorted nightmare of his horror. He did not know it yet . . . but he had need of all the beauty of the lake below and of the Alps above to restore the finite to its place. For the first time in his life, Mont Blanc looked to him what it was—a chaos of anarchic and purposeless forces—and he needed days of repose to see it clothe itself again with the illusions of his senses, the white purity of its snows, the splendor of its light, and the infinity of its heavenly peace." (p. 289)

The Freudian cannot help but wish that Adams had been less reticent concerning the details of his marriage, so that it might be known whether his wife was a feminine type that approximated his sister ideal. Such an unconscious fixation upon the sister is not uncommon, as Rank[1] and others have shown, and Adams' almost complete domination by the power motive would favor an arrest of the libido in its development. Slight though the evidence is, we may at least speculatively advance the tentative conclusion that his sex life was centered about an unconscious sister complex. Perhaps it was also such a sister complex that inspired the idea worked out by Saint-Gaudens for the Rock Creek Cemetery statue, which has been described "as both sexless and passionless, a figure for which there posed sometimes a man, sometimes a woman."

More normal is the hint of eroticism in the sensual appeal of spring and autumn to Adams' young manhood. He revels in their beauties in a manner which suggests that the old seasonal sexual rhythm, which found expression in religious orgies at the times of planting and harvesting in the days of phallic worship, still stirs human nature with its memories. In a sensitive neurotic temperament like that of Adams', responsive alike to external stimuli and the internal reverberations of race memories, it is not surprising to find this seasonal rhythm so intensified that he cannot help but note its existence, although, in strict accord with psychoanalytic mechanism, he projects his emotion upon its visible symbol—the beauties of nature.

Of the emotions thus engendered, Adams says: "The first effect of this leap into the unknown was a fit of low spirits new to the young man's education; due in part to the overpowering beauty and sweetness of the Maryland autumn, almost unendurable for its strain

[1] Rank, Otto. Das Inzest-Motiv in Dichtung und Sage. Leipzig und Wien: Denticke, 1912.

on one who had toned his life down to the November grays and browns of Northern Europe. Life could not go on so beautiful and so sad. Luckily, no one else felt it or knew it. He bore it as well as he could, and when he picked himself up, winter had come and he was settled in bachelor's quarters. . . ." (p. 255)

Quite as evident is the sensual element in his appreciation of the Southern spring: "The Potomac and its tributaries squandered beauty. . . . Here and there a negro log cabin alone disturbed the dogwood and the Judas tree, the azalea and the laurel. The tulip and the chestnut gave no sense of struggle against a stingy nature. The soft, full outlines of the landscape carried no hidden horror of glaciers in its bosom. The brooding heat of the profligate vegetation; the cool charm of the running water; the terrific splendor of the June thunder gust in the deep and solitary woods, were all sensual, animal, elemental. No European spring had shown him the same intermixture of delicate grace and passionate depravity that marked the Maryland May. He loved it too much, as though it were Greek and half human." (p. 268)

It was not until late in his life, however, that any marked expression of his sexual nature was revealed. At the approach of senescence there is ordinarily a final flare-up of the sexual instinct before it is completely extinguished. In the case of Henry Adams, this had as indirect an expression as the responsive thrill to natural beauties of his late adolescence. An absorbing interest in the American woman and her problems was one instance of this increased sexuality. Philosophical speculations concerning sex and especially the feminine principle was another.

From the beginning, the marvelous mechanical inventions of his age—especially the electric dynamo—had filled Adams with a sense of the existence of a mysterious power, little understood by mankind, but capable of manifesting itself in the most unexpected manner. The discovery of radium by the Curies increased this sense of a mystery shrouding the unknown forces of the cosmos, and the beginning of the twentieth century found Adams struggling to understand these new factors of human destiny, and to fit them into an orderly theory of historical method.

As the new and unaccustomed sexual desire temporarily flooded his life, woman, too, took on the same mysterious properties that possessed the rest of the universe, and he came to feel that the most powerful form of the great cosmic force was the reproductive principle which was best expressed in woman. It was a method of reasoning analagous to that of primitive man, who, unable to understand the attraction of the female, came to envisage her as the carrier of a mysterious, magical energy which was held to be a good or bad influence accord-

ingly as his instinctive sexual life chanced to be hygienic or unhygienic. So Henry Adams, whom a long life of erotic repression and arrest had left wholly unprepared for the pre-senescent outburst of sex, came to believe that this new power which modern science was revealing in so many varied forms centered in woman, and was not to be understood apart from the reproductive function and feminine attraction.

Here, then, was a new and illuminating theory of history, one that had never been suggested before, but that seemed quite logical in the light of these new feeling-thoughts which were taking shape in his consciousness. He began a passionate study of all the women who had figured in human affairs, and attempted to arrange historical facts around the central idea of sexual forces, and to show all events as the direct results of the action of the reproductive instinct in human life. "Early Institutions lost their interest," he remarks, "but Early Women became a passion. Without understanding movement of sex, history seemed mere pedantry." (p. 442)

As time passed, and Adams' fleeting sexual ardor cooled and finally disappeared, this theory of history, like all the others he had considered, was cast aside as untenable, and he evolved one which satisfied him more completely because it answered the problems with which his unconscious had been struggling, and became, in a sense, a projection of the ungratified desires which had made his career seem so disappointing and had kept him restlessly seeking all his life for the education which he felt that he had missed.

The climax of Henry Adams' autobiographical study, as of his whole psychic life, is the exposition of his final theory of history. And yet, as has been intimated, this theory was but the inevitable outcome of his unconscious complexes and mental conflicts. The starting point of this dynamic theory is the conception of power manifesting itself in a multitude of minor forces, and history is the account of man's long struggle to acquire the mastery over an increasing number of these forces. "Man's function as a force of nature was to assimilate other forces as he assimilated food. He called it the love of power." (p. 475)

The first great energy which man discovered was emotional, and to its most powerful form he gave the name of religion. The highest point of this emotional force became sensible in the ecstatic state of the mystics, in the days of scholastic philosophy. Because it found no more tangible form of energy, the Roman Empire fell, and the Dark Ages engulfed the world until the dawn of a new era of power, of a more material nature. At first the Church struggled against the new forces of early science, and persecuted the men who were revealing them. But the accretion of these new forces, chemical and me-

chanical, grew in volume until they had acquired sufficient mass to take the place of the old religious power, and substituted the attraction of natural forces for the mystic power of God. (pp. 476, 485) During the nineteenth century, the number of these forces had increased so greatly that man himself was almost overwhelmed by the energies he had liberated, and could only strive blindly to become their master. (p. 486)

From this mere outline of the main points in Henry Adams' dynamic theory of history, its formulation in accord with the unconscious impulses that shaped all the other reactions of his life is apparent. Governed from earliest childhood by the desire for power, a longing which the events of his life never gratified because his ambitions had been fashioned irrevocably by his unconscious grandfather ideal, he came to feel that all men were actuated by the same craving as that which filled his own soul. It was an entirely subjective reality, but it seemed more certain to his hesitant and doubtful neurotic temperament than the strange events of his age—the unexpected wars, the evolutionary theories, the scientific discoveries—all of which only deepened the sense of his own helplessness and reinforced his longing for power. And so, when he came to shape a final theory of history, which should be dynamic instead of static, he could find only one motive that seemed to him to dominate the life of mankind, and rejecting the idea of any unconscious evolutionary tendency at work in human affairs, he postulated the never-ending struggle for power which had been the vital factor in his own restless, dissatisfied personal life.

P. Blanchard.

Crime and Criminals. By Charles Arthur Mercier, M.D., F.R.C.P., F.R.C.S. New York: Henry Holt and Company, 1919. 290 p.

As psychiatry lagged behind general medicine for some hundreds of years, so the investigation of criminal conduct by psychiatry has lagged behind psychiatry. It is comparatively recently that psychiatry has given its attention to this particular field, but the results obtained promise much for the future. Already the profession has created a different public attitude toward the insane, the feebleminded, and the epileptic criminal. No intelligent person will dispute the desirability of treating these classes in a special manner and not by the ordinary penal methods. After the elimination of these three classes, there is found among individuals who come in conflict with the criminal law a rather large percentage of persons of sufficiently abnormal make-up to warrant their careful study and possibly a psychiatrical solution of their difficulties. From the pen of a psychiatrist,

one looks for a thorough discussion of the possible mental factors that may be operating to produce criminal misbehavior. In this the work under review is disappointing. Dr. Mercier does not recognize this group, or at least he makes no mention of it. He attaches no importance to the possible operations of the unconscious or the subconscious in any criminal misconduct. In this we do not agree with him. Careful studies have brought to light in a sufficient number of cases complexes which in a defensive way manifested themselves in criminality.

The central idea of the work appears to be the development of the importance in crime of the internal factor, or self-control, and the external factor—opportunity or temptation. The explanation that the overcoming of one or the other factor results in misconduct is entirely correct so far as it goes, but it does not explain why in certain individuals the internal factor or the external factor reacts so much more readily than in the average normal person. This naturally leads us to examine into the mental control mechanisms of such individuals and the causes of their disorders if any. The question what sort of persons reach their "breaking points" quickly in the face of the external factor has led to calls for psychiatry for an explanation. The classification of offenses is well done.

The division of criminals for the purposes of treatment into (a) habitual criminals who are past reformation, (b) occasional criminals who do not need reformation, and (c) young criminals for whom reformatory measures are of value, does not satisfy. Unfortunately we are not always able to reach the young criminal early enough. The occasional criminal of to-day may be the repeater of to-morrow, and sometimes a criminal termed habitual mends his ways. At any rate, an attitude that a particular class is hopeless tends to retard research.

The book on the whole is well written and interesting as giving the views of the author, but it cannot be said to add to our present knowledge of the subject.

Amos T. Baker.

Psychology of the Normal and Subnormal. By Henry H. Goddard, A.M., Ph.D. New York: Dodd, Mead, and Company, 1919. 349 p.

This book is evidently designed for a textbook in psychology. It purports to be an elementary statement of the operations of the human mind.

Strong points in the book are:

1. The endeavor to present mental operations to the eye through abundant illustrations of the organization of the nervous system. There are forty illustrations in the sixteen pages of text of Chapter I, on the Nervous System.

2. The use of concrete material from general literature and art, such as Helen Keller's first grasp of the meaning of language; the overinhibition of Julius, in *David Harum,* preventing him from taking off either the black shoe or the tan shoe; Millet's, *The Man With the Hoe;* and Edwin Markham's poem of the same name.

3. The intimate causal relation of the working of the autonomic nervous system to the emotions as demonstrated by Mosso and Cannon.

4. The presentation by the author of the results of his long experience with the feebleminded; he spent months (p. 49) observing idiots, trying to account for their repetitive movements. This constitutes the greatest difference between this and other textbooks of psychology, as the author admits. Many useful illustrations of the reactions of the "arrested" are adduced throughout the text.

The feebleminded, just like the insane, children, primitive people, and animals, do present variations and exaggerations of the normal human processes. These do amount to caricatures. Like all caricatures, they serve to emphasize and present in a striking manner operations of the mental mechanism which are not exposed by purely introspective psychology. Some of these operations are shown in a peculiarly striking manner by the behavior of Binet's "Children of the Good Lord," who are standing still at low levels of development.

For a general text introductory to the subject of psychology, the author overworks material from this source. For the student who approaches psychology with a desire to understand the minds of the retarded and the arrested—as, for example, the teacher in training for "special school" work, or the psychiatric social worker in training—this book is most admirably adapted. For such students, it presents a general outline of psychology, and at the same time affords the desired insight into the workings of the subnormal mind.

THOMAS H. HAINES.

THE PSYCHOLOGY AND PEDAGOGY OF ANGER. By Roy Franklin Richardson. Educational Psychology Monographs No. 19. Baltimore: Warwick and York, 1916. 120 p.

Notwithstanding the efforts of a great many psychologists in this country to make of psychology a study of the reactions of the whole individual in relation to his environment, this book is a straight introspective study along the narrow lines that were in vogue twenty years ago. Chapter 1 is devoted to the mental situation stimulating anger, Chapter 2 to the "behavior" of consciousness during anger, Chapter 3 to the disappearance of anger in consciousness, Chapter 4 to the conscious after-effects, Chapter 5 to the effect of education upon anger. The method adopted was to take ten graduate students of Clark University and two persons outside of the university and to get

them to observe the emotion of anger in themselves for at least three months. They reported to the writer each day, reading their introspections to him. The author refuses an apology for the uncontrolled conditions of introspection on the ground that emotions are involuntary and consequently do not lend themselves to the voluntary control necessary for laboratory technique. As may be inferred from this method of studying the emotion of anger, the body of the text is concerned with statements about the various subjects' own moments of irritation and anger. One looks in vain in these various chapters for methods of studying anger that might yield results somewhat broader than the scholastic formulations of Titchener. There is a growing body of students in the world of psychology who are interested in something besides the mere verbal behavior which one gets by the use of such methods. One would like to be shown in *experimental terms* what the effect of a good fit of anger is upon present adjustments and upon the immediate and more remote subsequent adjustments of the individual. For example, is the day's work spoiled by a fit of anger indulged in in the early morning hours, or is the effect of anger purely transitory, leaving the subject fit to resume his daily activities as soon as the state is over. What is the effect of the state of anger upon the subject's capacity for learning? In how far can states of anger be traced to previous maladjustments in the life of the individual?

Apparently the only effect the behavioristic movement in psychology has had upon this author is to be seen in the choice of the heading of Chapter 2: The "Behavior" of Consciousness in Anger. Apparently some of the introspectionists feel that when they have used the term "behavior" of consciousness, they have yielded all that they need to yield to the behavior movement. This use of the term behavior is totally unjustified, and if it is persisted in, will succeed in introducing into the straight scientific concept of behavior that same mysticism which surrounds the other concepts employed by the introspectionists.

JOHN B. WATSON

MANUAL OF EXERCISES FOR THE CORRECTION OF SPEECH DISORDERS. By May Kirk Scripture and Eugene Jackson. Philadelphia: F. A. Davis Company, 1919. 236 p.

This book is a collection of exercises involving the use of the speech mechanism. It is arranged in fifty lessons with an additional brief description of the sounds used in English speech. It contains a variety of exercises, many of them of much value, including drills for breathing, rhythm, the vowel sounds, and the consonant formations.

The authors say in part, "In the correction of speech defects at our

clinic, our procedure is more along psychological than physiological lines for the stutterer, although we are well aware that even these measures avail very little where it is necessary for the patient to have, among other things, complete change of environment, a correction of posture, physical training, etc.'' But, with the exception of a brief preface and introduction, the theory of speech disorders and the explanation of the methods to be used in the correction of ''stuttering, lisping, and cluttering'' are not included in this book. For this the reader is referred to the *Laryngascope* for 1918. Without a discussion of these conditions, this volume is of no practical value to any but trained speech teachers, who alone would be able to select from the immense amount of material that suited to the individual case. The authors say also, ''Let it be borne in mind that lispers and all other speech defectives need drill, not only on the particular consonants which give trouble, but on all sounds, especially the vowels. They will be benefited, therefore, as much as stutterers by going over every exercise in the book.'' With the construction which this statement necessarily puts on the defects of speech, issue must be taken. Stuttering, letter substitution, the oral inactivities cannot be considered as disease entities, but as symptoms, and therefore ''shotgun'' prescriptions for their relief cannot be recommended. The necessity for unguided selection of exercises points the danger in indiscriminate prescription of exercises of a reëducational nature. In the hands of a highly trained speech specialist, able to distinguish between the hysterical and the motor types of stuttering, or to decide the relative value of each in mixed types—between lisping as a prodrome of stuttering and lisping as a residual of poor coördinational training in infancy; between oral inactivity as a symptom of depressive insanity, paresis, and oral inactivity as a concomitant of feeblemindedness—and therefore able to prescribe the type of exercise best suited to the remedying of the underlying condition, this book has a very definite value. It has, however, little to recommend it to the general physician, parent, or grade teacher.

SMILEY BLANTON.

THE PSYCHOLOGY OF CONVICTION By Joseph Jastrow. Boston: Houghton Mifflin Company, 1918. 387 p.

Professor Jastrow is no less known as a master of literary quality than as a man of science. The present essays discuss origins and maintenance of different kinds of belief, taking up various definite convictions as ''cases.'' There is historical perspective, and an insight imparted into the meaning and characteristics of scientific method that commends the book, in some earlier portions at least, especially to younger graduate students. The fourth, fifth, and sixth chapters—

Paladino, Character and Temperament, Animal Psychology—stand out in this respect. Some of the papers have appeared individually, and while the thread of conviction as a wish-fulfilment ("will to believe") runs more or less through them all, each is complete in its own setting. The book is nearly free from the apparatus of notes, learned or otherwise, but the "case" method brings out interesting material on the phylogenesis of beliefs that hardly comes to the student through his ordinary channels for this information.

A book primarily designed to carry a viewpoint of psychological science to the liberally cultured reader not improperly remains within the sphere of general scientific agreements. Vigorous argument is not wanting on other issues, as concerning antivivisection and the Red Cross. The task Professor Jastrow has set himself is necessarily more difficult in the themes of Indulgence, the Feminine Mind, the issues of Militarism and Pacifism. The author's special aptitudes of expression show here to at least equal advantage, though the reader may not take away such distinct conclusions as are afforded by the remainder of the volume. Like the electric cake that was full of currants, the "Feminine" chapter is most adorned by its elegant figures. The final essay is noteworthy in the wealth of rationalizations cited for the militarist and pacifist positions, probably in more balanced fulness than these have ever before been gathered together. And though material cited may be familiar to the specialist, profit of pleasure is achieved through excellence in formal presentation.

F. L. Wells.

Essentials of Social Psychology. By Emory S. Bogardus, Ph.D. Los Angeles: University of Southern California, 1919. 159 p.

In compressed form this book furnishes abundant material for the successful teaching of social psychology by means of problem assignments. Each chapter treats a special topic of the science and provides the student with a brief summary of information, a careful selection of readings, and a series of problems. The bibliography of articles and books is adequate. The book will prove a valuable assistance to instructors who wish their students to learn to think for themselves in the field of social psychology.

Ernest R. Groves.

Psychiatric-Neurologic Examination Methods. By August Wimmer, M.D. Translated by Andrew W. Hoisholt, M.D. St. Louis: C. V. Mosby Company, 1919. 172 p.

This book "is meant to be a guide in making psychiatric-neurologic examinations, for the use of students and physicians in general." It

is seriously to be doubted whether this work would be of any value to the novice in psychiatry, and it is certain that the professional neurologist and psychiatrist would have little or no need for it.

The psychiatric material presented is poorly grouped and expressed (possibly the latter fault is due to the translation) and terms are used in rather an extraordinary manner, as for example on page 10, where the word "psychoneurosis" is used as if it meant "psychosis." Throughout the book italics occur which are without any discoverable rule as to emphasis. Most important of all, the psychology of the book is quite primitive and out of date.

The neurological data of examination are much better presented, and the language is far clearer and more English in its idioms. But though there is fairly full description of the individual tests and circumstances, the broad general principles underlying their genesis, occurrence, and disappearance are not presented, and therefore no student could make a practical use of the instructions given.

After all, it is very doubtful if any book on methods which does not deal as well with disease entities and diagnostic principles is of value either to the novice or the practitioner.

A. Myerson.

Applied Eugenics. By Paul Popenoe and Roswell R. Johnson. New York: The Macmillan Company, 1918. 459 p.

Mr. Paul Popenoe, formerly editor of the *Journal of Heredity* and now one of the general secretaries of the American Social Hygiene Association, has coöperated with Professor Roswell H. Johnson of the University of Pittsburgh in the preparation of a very useful compendium of "Applied Eugenics." This comprises twenty chapters and six appendices. First is discussed the relative rôle of nature and nurture, in which an attempt is made to set right those who know the word "heredity," but only a little of its real basis and meaning. Then are discussed the questions of the multiplication of the germ plasm and the law of variations. The general laws of heredity are set forth. Natural selection is discussed; the methods of increasing the marriage rate and the birth rate of the superior are considered. The growth of the eugenics movement has a chapter devoted to it and the relation to eugenics of immigration, war, and genealogy are considered in some detail. Brief reference is made to the eugenical bearing of such matters as taxation, the back-to-the-farm movement, democracy, socialism, child labor, compulsory education, vocational guidance and training, minimum wage, mothers' pensions, feminism, housing, old-age pensions, the sex-hygiene movement, trade unionism, prohibition, and pedagogical celibacy. On many of the topics mentioned above data have been brought together more completely than ever

before in a single book. The work is fully illustrated, and extensive tabular data are provided. There is a summary of Mendelian inheritance of human traits, a list of works of reference, and a glossary. Altogether, this book constitutes the best textbook of the subject of which it treats. The bearings of eugenics are, however, so extensive that one cannot say that the whole field has been adequately treated; it would require several volumes to do that.

CHARLES B. DAVENPORT.

PERSONALITY AND CONDUCT. By Maurice Parmelee, Ph.D. New York: Moffat, Yard, and Company, 1918. 283 p.

MIND AND CONDUCT. By Henry Rutgers Marshall, L.H.D., D.S. New York: Charles Scribner's Sons, 1919. 236 p.

There is need at the present time for a book that will deal adequately with the relationship personality and mind have to conduct. There are a number of excellent books that deal with phases of the problem, but there is no single book that one can recommend without reservations. Neither the book by Professor Parmelee nor the one by Professor Marshall meets this need. In fact, so far short do they fall that one regrets that two such excellent titles have been preëmpted by two such inadequate books.

Were there a Pure Book Law as well as a Pure Food Law, one questions whether Professor Parmelee's book could have been issued at all with such a title. It might have been permitted to squeeze by. But certainly the publishers would not have been permitted to announce on the cover slip: "'Know Thyself,' urged the philosopher. This book, by a great authority, teaches one to know one's self and to develop one's character." It does nothing of the sort. A few lines in the preface and most of the first chapter (seven pages) may be said to give promise of this, but little more is heard of the matter until, after two hundred and sixty-eight pages, one comes to the last chapter, which is entitled "The Development of Personality." When one points out that this chapter consists of five and a quarter pages, nothing more need be said as to its adequacy. In more than two hundred and fifty pages between the first and last chapters, Professor Parmelee gives his views on more or less recent legislation pertaining to alcohol and drugs, gambling and sex. For the most part he would seem to object to almost all the regulations various communities have felt it necessary to enforce in an effort to control the various evils that are found to grow from the above—the White Slave Law, the Injunction and Abatement Law, etc. One frequently agrees with what he has to say, but one cannot forget the manner in which he has almost tricked us into reading his views. Of course, Professor Parme-

lee makes an effort to hook these many pages of social argument to his title—"The spontaneous expression of human nature should therefore be encouraged in order to bring to fruition as far as possible the inherent potentialities of the individual. Excessive social regulation checks unduly the spontaneity of human nature."

Students of personality will find little of value in the book; students of social problems who have kept in touch with current discussions on the subjects of alcohol, drugs, gambling, and sex will not need to read it.

Professor Marshall's book is composed of the Morse Lectures delivered in 1919 at the Union Theological Seminary. As one finishes the book, one feels there is reason to regret the passing of the old fashion in titles. They were a bit long and a bit awkward, perhaps, but they were explicit—*The Works of Benjamin Franklin; Containing Political and Historical Facts Not Included in any Former Edition and Many Letters, Official and Private, not hitherto Published, with Notes and Life of the Author;* and *William Penn in America, or an Account of His Life from the Time he received the Grant of Pennsylvania in* 1681 *until his Final Return to England, giving, as far as possible, His Everyday Occurrences while in the Province;* or, in this case, *Conduct and Mind; a Preliminary Statement,* or, *Conduct and Mind—Certain Fundamental Considerations, with an Interesting and Instructive Review of Various Philosophical Views, beginning with Aristotle.*

The book could have been written in almost any period; there is practically no mention of any recent work on the subject. One looks in vain for reference to Healy, for example. Cannon is mentioned, as are Morton Prince, Shand, and Woodward. Freud is mentioned once and dismissed in a brief paragraph ending, "The study of the nature of these latter states of consciousness, while valuable, without doubt, in special instances, would appear to be of distinctly minor importance, in relation to the conduct of civilized man."

It is not to be assumed, perhaps, that the knowledge of the students at the Union Theological Seminary—Union of all places—on the subject of conduct and mind is confined to the limits of this book. It is to be hoped not. So long as the knowledge of theological students on such an important subject is so confined, graduates will continue to find themselves handicapped in dealing with problems of conduct. Professor Marshall himself would probably not consider the material in his book adequate, but he nowhere indicates as much, and his choice of a title of such scope leads one to wonder. The book has its value, however, for those who desire a background of philosophy and academic psychology as a preliminary to further study of the subject of mind and conduct.

FRANKWOOD E. WILLIAMS.

The Autonomic Functions and the Personality. By Edward J. Kempf, M.D. New York: Nervous and Mental Disease Publishing Company, 1918. (Nervous and Mental Disease Monograph Series No. 28.) 155 p.

The attempt to elucidate the innate nature of human personality has usurped the psychologic mind with somewhat the same vigor and tenacity as the attempt to determine the personality of God has that of the clergy. Perhaps the problem is too complex and vast for any solution, but speculations as to the factors that modify and qualify the human personality are certainly within the realm of useful effort. The subject is so intimately bound up with the nature of self-consciousness itself that one can scarcely hope to do more than indicate the modifiers of personality and not its real nature or seat. Just what electricity is, life, gravity, and other natural phenomena, are problems subject to the same laws of study. Purely as a study, however, the subject is not without scientific value, even though it but demonstrates a new way of thinking about personality. Kempf's work is an instance in point. In his work he has attempted to show how the autonomic apparatus dominates the organism, and that the affections have their origin in the peripheral functions of this apparatus.

"At present there is an unusually strong tendency among behaviorists and biologists to urge psycho-biological conceptions that include the personality as a whole, following the suggestions of Hughlings Jackson, on the three integrative levels—structural, physiological, and psychological. This is particularly valuable in that it discourages the adoption of the old, sinister, soul-body, parallelistic notions of the personality which have so long diverted enthusiasm and obscured the vision of psycho-biological researchers. On the other hand, the movement encourages the substitution of a practical monistic conception of the personality and promises marked practical results.

"Experimental data, psychopathological data, and observations of spontaneous behavior have been used to demonstrate the nature of the autonomic influence upon the structure and behavior of the individual.

"In Part I, the plan of the structure or anatomy of the higher organisms is discussed to show that since the process of atrophy of disuse tends to eliminate the useless material and movements on the one hand, and the growth of the useful tends to make permanent necessary material and movements on the other, the architecture of an animal should reveal in a general, but reliable manner the fundamental law or process that determined the peculiar form of its existence.

"Part II is devoted to a consideration of such physiological data as are suited to demonstrate the dominant nature of the autonomic apparatus. The interpretation of (1) the continuity of postural tonus

of the striped muscles as the source of a continuous kinesthetic stream, and of (2) the unstriped muscles as the source of a continuous affective stream, is based principally on the physiological researches of Sherrington and Langelaan and on introspective observations of spontaneous reactions. Researches of Cannon and Sherrington on the nature and origin of hunger and fear, and the laboratory demonstration of the peripheral origin of the desire to urinate are advanced to demonstrate the peripheral origin of the affective cravings in the autonomic functions. The same research material, plus other data, is used in order to show that emotions are not experienced upon the cerebral changes that precede the autonomic changes, but that an emotion only comes into existence as the peripheral autonomic reactions become active.

"The more popular conceptions of emotions and instincts show that there is an illy defined tendency among psychologists to differentiate them according to the physiological functions involved. In Part III, this material is advanced to stabilize the primary effort of the monograph, namely, to obtain recognition for the fact that in the higher organisms an affective sensori-motor system (autonomic) exists which created and uses the cerebro-spinal or projicient sensori-motor system as a means to keep in contact with the environment in order that the autonomic apparatus may fulfill its biological career.

"Part IV is devoted to a brief restatement of the functional principles of the personality with some consideration of man's place in nature. The references are listed at the end of the book."

The manner of presenting his thesis is excellent, and while Kempf cannot be said to have proven it, his work is worth while, and a careful consideration of his contentions will be necessary in our further study of the great problem of the functioning of the autonomic system and the personality.

L. Pierce Clark.

Psychoses of the War. By H. C. Marr, Lieutenant Colonel, R.A.M.C. (Temporary). New York: Oxford University Press, 1919. 280 p.

This book is based upon the observation of 18,000 cases of mental disorders in soldiers. It is a resume of the literature written during the past four years. The author devotes about one-half of the book to the discussion of "shell shock." He takes up in a superficial manner the mechanism of the various types of the neuroses, presenting numerous case histories as illustrations.

His classification of the psychoses, as well as of the neuroses, is one that has long been discarded. He adheres to the classification: *folie*

circulaire, primary mania, primary melancholia, and primary dementia.

Marr's statistics are rather interesting and conform to the statistics of other writers of wide experience. In the 18,000 cases observed no case of idiopathic epilepsy was found that was directly traceable to the effects of the war. Of 353 soldiers in whom it had been certified by a medical man that a true epileptic convulsion had been observed, or whose mental condition or history exhibited all the mental characteristics of idiopathic epilepsy, all gave histories of having had pre-war convulsions or epileptic manifestations.

In the latter part of the book considerable space is given to the physiology and examination of the spinal fluid and to history taking. This book would be most serviceable to the medical man not deeply interested in psychiatry.

C. J. D'Alton.

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CHILDHOOD: THE GOLDEN PERIOD FOR MENTAL HYGIENE*

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THE outstanding fact that present-day psychiatry emphasizes is that mental illness is a type of reaction of the individual to his problems of adjustment which is conditioned by two factors—the nature of those problems and the character equipment with which they are met.

The first of these factors, the nature of the problems, we can dismiss with the general statement that any individual, theoretically at least, may break under the stresses of adjustment if only the stresses are sufficiently great. For any material, be it physical or mental, no matter how strong its make-up, a force may be conceived great enough to break it.

The second of these factors, the character equipment, is the important one for our consideration in this connection, for mental hygiene is calculated to reinforce the weak points in character while it may often be at a loss to change the nature of the problems which present themselves for solution, although both factors are proper subjects for its consideration.

A generation ago, psychiatry approached the various types of maladjustment from a purely descriptive standpoint, classifying the several disease pictures solely upon an enumeration of the symptoms. This was the period of studying mental illness in cross section. Later, under the influence of

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the Kraepelinian teaching, mental illnesses were classified upon the basis of their course and outcome. This was the period of studying mental illnesses in longitudinal section. To-day it is generally accepted that mental illnesses are only reactions of the individual as a whole. Pathological reactions, then, are only a portion of the total behavior of the individual and can be understood only after a sufficient analysis of the personality make-up has made clear how the symptoms are the outcome of a certain character equipment brought to bear upon certain problems of adjustment. This is the period of behavioristic psychology and interpretative psychiatry.

Mental illnesses, defects of adjustment at the psychological level, are therefore dependent upon defects in the personality make-up, and as this personality make-up is what it is as a result of its development from infancy onward, it follows that the foundation of those defects which later issue in mental illness are to be found in the past history of that development.

This is a somewhat abstract statement of what is found, as a matter of fact, in every psychosis as it passes in review in our clinical work. A study of the individual patient always discloses elements in the character make-up which have made for maladjustment over a period of years until finally, owing to some acute disaster or merely by the accumulation of stresses, the breaks or, in individuals more seriously burdened, the defects have conditioned a series of pathological symptoms which have resulted in marked and more or less continuous inefficiency. In other words, mental illnesses are found to be the outward and evident signs of intra-psychic difficulties—conflicts we call them—which conflicts in turn are found to be dependent upon traits of character that have their origins in the childhood of the individual. The capability of the individual for efficient adjustment becomes progressively weakened much after the analogy of two lines that start at a given point and pursue diverging courses. Finally they get so far apart that no bridging of the distance is possible; each pursues its own course independent of the other, and we have the symptoms, for example, of a split personality.

It is natural that character defects should first have attracted attention and been studied in those conditions in which the defects have produced gross and easily observable symptoms. A study of these gross defects of adjustment has

shown, however, that the important etiological factors are not nearly as obvious as they were originally supposed to be, but on the contrary they are constituted of subtle defects which have been, often for long periods, quite successfully hidden from view.

The particular trait of character with which the individual has been struggling all his life—suspicion, cruelty, jealousy, timidity, curiosity, overconsciousness, etc.—the trait about which his difficulties arrange themselves, will be found on analysis to have been unfortunately conditioned early in life as a result of the influences exerted by the various members of the family or their surrogates. There is as yet no adequate appreciation of the continuity with which we express our affective states in our postural attitudes, our facial expressions, our voices, mannerisms, remarks, opinions, interests, aversions, and how subtly, half-consciously, often quite unconsciously, we read these signs in those about us and are correspondingly influenced. This personal world we live in is "not a world of formal thought only, but more a world of feeling, and moreover a sentience so exquisitely fine and fluent as many times to be scarce conscious of itself and quite unconscious of its causal antecedents."[1] The child in the family is one part of an organism which is highly responsive to all that goes on in that organism. The influences which thus reach the child find it peculiarly plastic, much more so than later in life when the main character traits have become firmly established, structuralized.

All of this points quite unequivocally to the period of childhood as the golden period for putting into effect the teachings of mental hygiene. It is the period *par excellence* for prophylaxis and therefore the period, above all others, which must be studied if psychiatry is ever to develop an effective program of prevention.

These statements will, I think, be pretty generally agreed to, but in this connection I wish to refer to certain tendencies of thinking which I believe have operated against this enlarged conception of the importance of the personality. I refer particularly to the thinking which has been dominated

[1] Maudsley, Henry. *Organic to Human, Psychological and Sociological.* London: Macmillan and Company, 1916.

by the germ-plasm theory of heredity and certain derivatives from this theory which have tended to the conclusion that practically all of our characteristics, mental as well as physical, are handed down to us by our ancestors and are something, therefore, which we can do very little about. The theory of the non-inheritance of acquired characters and the further theory that for every last trait there is a germ-plasm determiner has introduced a fatalistic element into our thinking which has made for a therapeutic nihilism by turning attention away from a consideration of the possibilities of effectively modifying the fundamental elements of the character make-up. In this connection Ritter[1] very aptly says that the germ-plasm dogma is "chargeable with the grave offense of having added its weight to a conception of human life the overcoming of which has been consciously or unconsciously man's aim throughout the whole vast drama of his hard, slow progress from lower to higher levels of civilization —the conception that his life is the result of forces against which his aspirations and efforts are impotent."

Even allowing that certain fundamental traits are inherited, that does not mean that nothing is to be accomplished in an effort to utilize those traits to better advantage. A congenital deaf mute does not have to give up all effort to communicate with his fellows just because he cannot do it in the usual way. A person may be from early childhood intensely curious. That does not mean that he must always use his curiosity in a socially offensive way. With proper opportunity and guidance, he may learn to use this trait to better and better advantage and may become a scientist utilizing his curiosity in searching out the secrets of nature rather than the secrets of his neighbors.

Apart from such considerations, however, there is much evidence that the theory of the continuity of the germ plasm and the non-inheritance of acquired characters, in fact the whole subject of heredity, will have to be materially modified, particularly as it relates to those mental traits that we are accustomed to observe in our fellows and our patients. Not only are certain biologists beginning to think of the germ

[1] Ritter, W. E. *The Unity of the Organism or the Organismal Conception of Life.* Boston: Richard G. Badger, 1919.

plasm as being a part of the organism as a whole rather than as a substance which is handed on from parents to offspring in unmodified form, but there is much evidence that mental traits, particularly those which later on make for defects of adjustment, precisely because these have attracted most attention, are developed in response to certain facts in the environment. For example, it is as logical to suppose that a son may develop traits like his father because he seeks to emulate him as it is to suppose that these traits were handed down to him through the medium of specific determiners in the germ plasm.[1]

If it is true that defects in the character make-up can be explained as originating in traits which were acquired in early childhood as reactions to certain factors in the child's environment, then the way is opened for an attempt to prevent such undesirable traits by an understanding of the child and a modification or elimination of those environmental factors which produce such results. For example, we all know many persons who are afraid of lightning, yet Watson tells us that in all the babies he has worked with he has never seen a reaction of fear to sudden flashes of light.[2]

If the fatalistic ways of thinking engendered by the theories of heredity can be put aside, then we find another reason for considering that the period of childhood offers the golden opportunity for mental hygiene and for realizing that this is the period upon which effort must finally be centered in the development of a program of prevention.

What are the points of attack for the development of such a program?

First, there must be a real understanding and development of child psychology. This development must be along the lines of behaviorism, a study of what the child is trying to do in terms of the child psyche. Here, as elsewhere in dealing

[1] See discussion of heredity in my *Mental Hygiene of Childhood.* Boston: Little, Brown and Company, 1919.

[2] On the other hand, he tells us that loud noises will produce the reaction of fear in very young children. As the lightning is usually followed by thunder, the flash itself is soon reacted to by fear on the principle of the conditioned reflex. Watson, John B.: *Practical and Theoretical Problems in Instinct and Habits* in *Suggestions of Modern Science Concerning Education.* New York: The Macmillan Company, 1918.

with children, the tendency has been to think of the child as if it were a small adult and to project upon it those types of explanation which we as adults have found satisfying in our own personal experience. A behavioristic child psychology must get away from this tendency and get at the original data from first-hand observation. Such a study of the development of types of reaction, a study of the primitive instincts and their unfolding in the more complex reactions as development progresses, is of the first importance.

Second, an understanding of the nature of the child's relations to its environment, particularly its personal environment and specifically to the members of the family, is also essential. Its relation to the family situation begins from the moment of birth, and from the symptoms that later develop in the psychoses we have come to learn how important those relations are for conditioning the later reactions for better or for worse. The fact has too long escaped notice that the family situation contains within itself certain elements of a disruptive nature.[1] It is as essential that the child should ultimately escape from its bondage to the family as it is that it should, during a certain period, be a part of that family and more or less subject to its direction. The complex interplay of these attractions and repulsions needs to be more fully studied as they express themselves in the symbolic mosaic at the psychological level.

And thirdly, a full understanding of all these matters must reach their application in education. Here again the effort has too often been to project upon the child something which we as adults may think desirable rather than to understand the equipment of the child and then try to develop that equipment in the best possible way. Education has been largely empirical and too much confined to teaching; it needs to be developed as a scheme for assisting and guiding the developing personality, based upon a real understanding of the principles involved and the equipment.

And finally, inasmuch as it cannot be expected that the child is going to acquire all this information and then apply it to itself, it is essential to develop some means whereby such information can be translated into effectiveness. The child is

[1] For a discussion of these elements, see my *Mental Hygiene of Childhood*.

so intimate and so all-pervading an element in our social structure that any organized effort to influence it profoundly in its development must needs touch every part of that structure. The obviously more important points of attack, however, are the home and the school, of which places probably the home offers the least encouragement. The relations between parents and children are governed for the most part by crude instinct and it would hardly seem that we either have organized knowledge in a sufficiently practical form or means at our disposal to alter this situation materially or even to interfere with it on a large scale, except in a superficial way, with anything like a sure touch. To be sure, much can be done by the trained social worker, but this is usually in cases where trouble already exists, and even such approaches must come largely through the schools. That this is so is perhaps unfortunate, for there are of necessity many problems that cannot be touched in this way except perchance through the family physician, who should become more and more a reliable source of information, advice, and strength as the teaching of psychiatry and kindred subjects broadens out in the medical schools. Take, for example, the problem of the unwelcome child—the impregnation which was accidental and not desired, the months of childbearing endured without joy, the pains of parturition that are borne in bitterness, and finally the child to be the recipient of all this accumulated feeling of resentment.[1] "What is the later story of such a life?" "How could it be modified to advantage?" are the immediate questions, but perhaps of greater significance is the query how the problem of the unwelcome child relates itself to one of the burning questions of the day—birth control and the use of contraceptive measures. Man's antipathetic tendencies, as well as his creative purposes, are sublimated and refined in the course of cultural evolution. The viable child is no longer plunged head down in a vase of water—the germ cells are not permitted in conjunction.

[1] These remarks are not intended to apply to phenomena usually considered under the designation "maternal impressions." I am referring only to the attitude of the mother toward a child that was not desired. Such an attitude conditions a feeling of inferiority which may be a serious handicap throughout life. A similar situation is produced when there are several children one of which is a favorite of the parents. In such a relationship the child feels keenly his inferiority in the family situation, as does the unwelcome child.

The school seems, therefore, to be the most practical place to work for results, although of course a great deal of knowledge must be acquired about the child before it is of school age. Work of this character we are trying to plan in Washington in connection with a private charity which ministers to the infant, helping the mother during her pregnancy and the child for the first six years. Arrived at the school, however, the teacher becomes the surrogate for the parent and perhaps in many ways, not only by education, but because of emotional detachment, is better calculated to be of real service than the parent. If the teachers, with the machinery of the schools, are going to be of real value, it will mean that the education in the normal school will have to be broadened, the final result of which will be somewhat older, more mature, better teachers, better paid.

All our approaches to the understanding of defective psychological adjustments point indubitably to childhood as the period when things first go wrong, and the indication is therefore clear that this is the period which must be studied and modified to prevent the failures of later life. A great mass of evidence has been accumulated which goes to show that serious breaks in adjustment do not ordinarily occur without the coöperation of some lack of balance in the personality make-up, that they are rarely to be satisfactorily accounted for by the influence of extraneous circumstances alone. This evidence has been accumulated from the study of actual breaks as we see them in our patients—breaks which we have come to look at only as end results. The studies which have been made of delinquents show this very well indeed—how, for example, the young man who has finally come to a long-term sentence in prison will almost invariably show, if a careful survey of his past life is made, a long series of conduct anomalies which make the final outcome not only understandable, but often quite inevitable. I have in mind a recent case that came under my observation. A negro ran amuck, broke into several dwellings, and in one shot and killed a young woman. He was convicted of murder in the first degree and sentenced to be hanged. A behavioristic survey of this man disclosed the fact that he had shown traits of lack of control, impulsive and irresponsible conduct from his early

youth, that he early began to drink and to take drugs, that he had been arrested and served sentences upon many occasions for both major and minor offenses, that there was all through his career a tendency to indulge in acts of violence and acts that were calculated to jeopardize the safety and the lives of others. The final homicide was the logical outcome of such a career, and at this late date execution seems rather a confession of impotence in dealing with this antisocial problem. No really intelligent plan had ever been brought to bear upon the problem he presented, but he was allowed to pursue his course to its logical outcome; whereupon society washes its hands of him finally and for all time. From the standpoint of responsibility, it might well be questioned which was the more responsible—the society that permitted all this or the defective youth who went his way.

One of the most important issues in mental hygiene, then, as I see it, is to correlate the sick adult with the knowledge we have that his illness is traceable in its beginnings to his early life. I have already indicated that this must be done by a more developed knowledge of the psychology of childhood, which is reflected in the home, in the school, and in the principles and methods of education. While all of this is true, we need not to lose sight of the fact that much work which is at present being carried on has mental hygiene implications, some very directly. Such work as the Child Bureau is doing in attempting to determine the minimum requirements of food, clothing, wages, etc., is obviously important. We must first have a live child if we are to have any problem at all. Efforts to improve the environment, even with reference to such obvious features as food, clothes, and ordinary sanitation, however, are not lacking in their general effect upon the mind of the developing child. Recent observations in the devastated countries of Europe have shown how quickly destitution, which takes all the joy out of life, is reflected in the mental make-up of the children. Here also come in such problems as the care of the pregnant woman, child labor, sex education, school sanitation, and more specifically the problems of the atypical child and juvenile delinquency, all of which can be better dealt with in proportion to our increased knowledge of child psychology, while such

social problems as marriage and divorce, and, as already indicated, birth control, have very direct bearings. All of these several factors will be seen to have their bearings when it is realized that the child is not a finished product, but the result of influences which play upon it from all these sources. It is a product of the past through heredity, of the innumerable elements, largely personal, of its environment, of its instincts as they work out in relation to that environment, of social and family traditions, and of the social standards of its time and place, and all of the various approaches indicated can be made more effective in the light of such knowledge. I am minded at this point to compare the broad behavioristic program that I have indicated with the restricted scheme that is spanned only too often by the Binet-Simon scale. This scale, as devised by its originators, may be a very valuable tool in the hands of a skilled observer, but as the "be all and end all" of child psychology it may become quite as vicious in its results as the fatalism inspired by the false theories of heredity I have already mentioned.

And finally, inasmuch as many of the breaks, perhaps most of them, occur in the adolescent period or the period of early adulthood, it would, to my mind, be of inestimable value if some help could be systematically extended to the youth when, if he has not as yet broken, the symptoms of final disaster are quite apt to be discoverable. This might easily be done while he is still in school or college, if there could be connected with each such institution an adviser skilled in matters psychological and sympathetic and understanding of the problems of the young. This is a matter to which Dr. Paton has called special attention. I feel sure that such an adviser, connected with our large universities, would soon establish a large and useful clinic to which a great number of the student body would resort for advice and assistance in dealing with their life problems as they are beginning to unfold at this most critical period of life. It is of the utmost necessity that not only should our schools and colleges be equipped to offer instruction in any branch of learning desired, but that the individual should be consulted as to his equipment, his personal tendencies and desires, his difficulties and shortcomings,

as well as his special aptitudes and opportunities. Unless this is done, the big educational machines will go on grinding out their regular proportion of failures. When it is done, those failures can be minimized and it may be found that not a few may profitably be turned away from a higher education to a life of greater usefulness in some other direction.

This is the sort of effort that is calculated to adjust the educational machine to the needs of the individual. To-day that machine offers a fixed structure into which the individual is fed, to come out well or ill in proportion to his capacity to meet the requirements. The means I suggest would have the effect of helping to adjust the educational opportunities to the needs of the individual and would be a movement towards individualizing the student just as we have learned in psychiatry that any material advances in therapeutic efficiency must come along with a further individualizing of our patients.

These are some of the directions in which my thought is led by a consideration of the mental hygiene of childhood. If we are to produce a better race of adults, we must be able to control the influences which go to mold the adult character. A practical program in this field seems to me to be possible, and to offer a decidedly more workable scheme than an effort to go back of the returns with the eugenist and control the material. The more we know of what can be accomplished with the material given us, the better position we will be in to undertake the control of what that material shall be.

THE ESSENTIALS OF AN EDUCATION

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THE interesting information given by Mr. Morgan in a recent number of the *Atlantic Monthly* in regard to the early life of Abraham Lincoln shows that, in spite of what are often considered to be limited opportunities, it was easier for the future president than it is to-day for the graduate of our high schools, colleges, and universities to get the essentials of an education. These essentials are (1) a knowledge of actual life, (2) a definite impelling interest in some special phase of life, (3) information gained from actual experience of a person's own adjusting capacity and limitations, and (4) the cultivation of the emotional attitudes and habits required for recognizing and facing reality. In thousands of ways it was strongly, but unconsciously impressed on the mind of the young Lincoln that life is a process of adjustment, that progress is slow, and that the person who does not face elementary biological facts squarely soon gets into serious difficulty. If Lincoln had not formed the habit of accepting life as it really is, serious trouble might have resulted from the emotional conflicts which at times resulted in mental depression. Even with this marked tendency, the personal problems never seemed to interfere with his judgment on public questions.

Lincoln also learned, quite unconsciously, that man's conscious processes are not so important in effecting adjustments as most people believe them to be. He grasped the principle, although it was probably not so definitely formulated in his mind as it was in the mind of Sir Joshua Reynolds, that "in art, in taste, in life, in speech, you decide from feeling and not from reason; that is, from the impression of a number of things in the mind, which impression is true and well founded, though you may not be able to account for it in the several particulars." Circumstances forced Lincoln to learn how to live successfully in a real world. Unlike a good many scien-

tific philosophers, he was never in doubt as to the reality of his environment, and he had an unusual opportunity to acquire a large store of valuable information about man as he is. Having acquired and digested this information, he was then well prepared to profit later by what history told him man was once supposed to have been.

As a result of his acquaintance with the facts of actual life, he was never misled by the intemperate idealist's visions of what he hoped man might become.

If Lincoln had not acquired a fund of information in regard to biological facts and had been forced by circumstances to accept the academic privileges of the day, the Gettysburg speech he might then have written would undoubtedly have attracted as little attention as the oration of the Harvard graduate delivered on that same memorable occasion.

Science to-day cannot explain Abraham Lincoln. Many of the facts in his heredity perplex the student of eugenics. We are in a position, however, to apply some of the lessons which stand out clearly in his biographies. As has already been intimated, little is known in reference to his inherited predispositions. He had a remarkably strong physical constitution and unusual traits of temperament and character, and these were supplemented by the addition not, as so many people believe, of only the rudiments, but of the essentials of education. In natural as well as in acquired possessions, he was superior to most Americans who have enjoyed the privileges of a so-called modern education.

Lincoln was square in his dealings with men not only because of a natural predisposition, but also as the result of having practised the difficult art of squaring up his accounts with life each day. Few educators appreciate the fundamental importance of this principle. Many graduates of educational institutions have never received an intimation from their teachers of the basis upon which the successful adjustment of life depends. During the process of civilization, man's vision seems to have become hypermetropic. One result has been that under academic tutelage a pupil has plenty of aid in visualizing the problems of man as he was or man as he may become, but few help him to analyze the reaction of man as he is.

Little provision is made in our educational system to-day to assist the student to know himself, to size up the present situation, and to adjust life intelligently to meet the demands of the immediate circumstances. Is it any wonder, then, that the preparation for actual life has not been, in the majority of cases, a great success? Entirely too much attention is paid to finding out *what* a pupil thinks, while the far more important subject of *how* he thinks is neglected, and until some tragedy occurs, the measure of success in adaptation is generally overlooked or forgotten.

Physicians are said to bury their mistakes, and the public often has an opportunity to trace the immediate connection between treatment and result. In the case of the educator, however, the connection between his treatment and his mistakes are not by any means obvious. A teacher has the opportunity to shift the responsibility for many of the tragic results of education to the shoulders of other people. This shifting process is not the result of premeditation or of any appreciation of the defects of the system. Educators as well as the public have been so thoroughly hypnotized by the academic conception of education that the failures, including graduates *cum summa laude,* from high schools and colleges who later appear in sanatoriums, hospitals for the insane, almshouses, reformatories, and prisons, or who develop the peculiar emotional unrest of the psychoneurotic, usually are not recognized as the products of the educational system.

The moment, however, we accept the truth that education should be a process of preparing a person to meet successfully the realities of life, then the connection between defects in the school or college training and failures in living treated in hospitals, reformatories, or prisons becomes startlingly apparent.

People who have acquired the essentials of an education are insured against nervous breakdowns, do not occupy positions they are not qualified to fill, are not intoxicated by intemperate idealism, do not develop a psychology of life based upon personal grouches or make the fatal mistake of persuading themselves that their own pronounced defense reactions against reality are virtues.

The academic conception of education is responsible for

more tragic failures than physicians would be if they decided to adopt a treatment of diseases based only upon its consideration of reported cures without taking into account either the partial or the complete failures. We must learn to see the educational problem in its broad relation to actual life and to understand that our failures either to understand what the essentials of an education are, or to give the student an opportunity to acquire these, has resulted in there being more patients in hospitals for the insane than there are students in colleges and universities and is adding steadily to the number of independents unable to adjust their lives satisfactorily, while increasing the incidence of those who resort to criminal methods in their vain efforts to find some kind of an adjustment in living.

Let us see what changes in the educational system commend themselves as both rational and feasible if the essentials for a successful and happy adjustment of life are made the basis of the plan. As every living being has to make some attempt to adjust life to reality, assistance should be given in cultivating a capacity to recognize reality as well as in the art of guaging the adjusting capacity and acquiring the emotional and mental attitudes requisite for meeting the actual conditions of life.

These essentials were obtained by Lincoln, but are not acquired by the majority of people. He had the opportunity of sensing the value of facing squarely actual situations in life, of doing his own thinking, of appreciating the fact that life is a struggle to adjust to present conditions and not those either in a remote past or in an anticipated future, of picking up a practical knowledge of his own personal adjusting capacity, together with an insight into the temperaments and characters of other people that was useful in supplementing and correcting his own impressions of life, and of realizing that honesty in meeting difficult situations paid and also that it did not pay to form the habit of substituting fictions or phrases for facts and concrete situations.

The character of Lincoln does not in any way suggest the miraculous. It would have done so, however, if he had succeeded in passing through the equivalent of our present educational system and still retained, unimpaired, his natural endowment.

Lincoln had an unusual endowment, physical and mental, but this would not have saved him from hopeless mediocrity if he had not had such an extraordinary opportunity to study man as he is. The practice he had in analyzing the personality of his friends and acquaintances at very close range gave him a very useful kind of information in regard to his own temperament and character. He studied human behavior and the reactions of living beings. History for him became a living reality, whereas for most students without his extraordinary amount of first-hand knowledge of the present, the past becomes a place of refuge for the imagination of those who do not understand the present.

Let us see what our present academic system does for the boy whose father is a practical, hard-headed business man without a notion that the present is related to the future as well as the past and, therefore, devoid of healthy idealism. The mother is high-strung, possesses a marked artistic temperament, and often is as intemperate an idealist as the father is a headstrong and pedantic pragmatist. The boy at a very early age in this home environment begins to dodge reality. Even before the self-conscious period has developed—usually about six or seven years of age—the youngster realizes that the reality of hunger sensations can be relieved by crying until he is fed. Soon he generalizes this experience and learns to recognize the value of an attack of the tantrums as a means of avoiding unpleasant situations. Often harshly rebuked by the father and gushingly sympathized with by the mother, the boy finds comfort in the reaction of believing that he is superior to his companions. In school and college, the defense reaction is greatly elaborated, often in a subtle and ingenious manner. After graduating with honor at the university, he selects an academic career and is taught a system of philosophy which he assumes is the only key to the study of reality. A person with some practical understanding of life also comprehends the motives which unconsciously drive the youth to take refuge from the world in an academic environment and an academic philosophy. The failure to face reality, subsequent suppressions, the effort to effect some kind of satisfactory compensation, few and narrowed channels for expressing his emotions, distort his mental vision and leave their mark upon his personality.

The next case is that of a young man whose parents were high-strung and possessed certain Brahminical characteristics. He was not a robust type and soon formed the habit of "sticking to his books while the other fellows played." In college he was a semi-recluse. He did not mind being called a "sissy," as he felt superior to his classmates, but any reflections upon his intellectual attainments were resented. Unfavorable criticism was keenly felt, and he would brood over what he considered to be a "slight." He "loved the classics" and "hated the practical sciences." A cynical attitude and a hypercritical spirit were indications of his elaborate system of defense against reality. At home he was the "spoiled member of the family." His intellectuality was contrasted with the mediocre attainments of a sister and brother. In this environment it is not surprising that he became conceited, egotistical, opinionated, and, except to his intellectual superiors, domineering and arrogant. Hard pressed upon all sides by the unpleasant realities of life, he dropped the discussion of personal problems and sought refuge in those of a general character. To hide his own grouches, he assumed an interest in social reform and soon became an enthusiastic radical.

He married a young woman of considerable intellectual attainment, but also of unstable type. The fact that his wife did not possess marked feminine characteristics or graces accentuated his chronic feeling of resentment. The memory of the chief incidents in this conflict was repressed, but their presence in the subconscious was symbolized in reactions against the person supposed to represent the social class from which he felt he had been excluded. Occasionally, in his saner moments, he admitted to himself what the real reason was for his exclusion from this social group, but whenever his emotions were aroused, the censorship suppressed the information. When war was declared, he became an ardent pacificist, as pacifism was for him the symbol of the personal peace he could not attain without a fundamental readjustment. Like so many other conscientious objectors, he preferred hating to fighting. Pacifism also gave expression to his skill in inventing a formula to remedy the defects of society. The mere repetition of a moral formula often relieves

the tension caused by embarrassment in facing a personal problem.

His general protective reactions against the hard knocks of everyday life were symbolized by his academic philosophy, his medievalism, his discontent with present conditions, and his desire to "live in those centuries when life was picturesque and had a peculiar charm of its own."

Like the boy who loses a fight, he dreamed of situations and an environment in which he could come off the winner.

This same kind of defense reaction occurs in the intellectuals who ridicule the present, idealize the past, encourage a mystic belief in medievalism, and declare the modern thinker has not any more to his credit than the pedants, grammarians, and various imitators living in a period of "a revival of learning." They, like the boy, have lost a sense of perspective as the result of some humiliating disappointment, while wishful-thinking has supplied a substitute for reality-thinking.

Whenever a young person faces a difficult situation and finds it impossible to readjust without a struggle, "the educator" should observe closely whether there is any tendency to apologize for defect or develop a grouch. The grouch may very easily be substituted for a normal, healthy reaction towards life, and this substitution or transference is generally recognized by:

(a) a tendency to replace facts by symbols
(b) the use of some general vague expression for a concise, accurate statement of fact
(c) a protective series of reactions in which both emotion and intellect play an important part.

Plenty of illustrations are available of the disorganizing effect on the personality caused by the avoidance of troublesome personal issues. We see what happens often in the case of some of the so-called intellectuals who have dodged troubles at home. They plead fanatically for open-mindedness, tolerance, and liberality in dealing with persons who cannot control their own emotions. With a fine pretence of charity and show of tolerance for the intolerable and the intolerant, they pretentiously declare "it is worth while giving

the Bolsheviki an opportunity to try out their theory of government." These quixotic intellectuals, however, have little or no appreciation or tolerance for the common-sense values in life. They dream of new republics, denounce and ridicule the present order, which is such a constant reminder of skeletons in the closets, and then attribute the woes of humanity, including their own, to the social class to which they think they do not belong. In giving aid and comfort to the forces of reaction, they find channels for relieving the tension due to their own suppressions and conflicts. We can get some idea of how common these psycho-pathological reactions are by reflecting upon the successful appeal made daily by the yellow and ultra-radical press to those who have distorted personalities and are adepts in wishful-thinking. There is little to choose, however, between the mystics who, living in academic atmospheres, are continually substituting for life as it is visions of what they would prefer to have it, and the sensation mongers or the supporters of jazz journals who display "an ebullience of misdirected emotion and incoherent thought."[1] Both the academic mystic and the jazz editor are trying to forget annoying personal problems, and each adopts his own particular method of camouflaging the line of retreat.

In beginning the formal part of the education, the teacher should constantly keep two biological principles in mind. In the first place, it should be well understood that every living being has certain innate dispositions which cannot be changed, but should be utilized to the best advantage in adjusting life to meet the demands made by the environment. In the second place, it is equally important that the needs created by these fundamental attitudes should be satisfied and the young person given an opportunity to sense the satisfaction of having successfully adjusted to reality. Most of the failures in life are due to the fact that little attention is paid to satisfying fundamental biological needs.

Data such as those suggested by the accompanying inventory should form the basis of the plan for the formal education. With a few weeks' instruction, an intelligent teacher would be competent to secure the information asked for in the chart.

[1] Ghent, W. J. The Jazz Journals. *The Review*, Vol. II, No. 35, p. 30.

Inventory of Educational Progress at Three Important Epochs

I Beginning of School Period
- a. Sex Age Weight
- b. General physical and emotional characteristics
- c. Capacity to stand and sit quietly
- d. Precision and coördination of spontaneous and voluntary movements
- e. Evidences of eye, ear, and motor mindedness.
- f. Signs of intelligent curiosity
- g. Fatigableness, mental and physical
- h. Signs of unusual or capricious development

II Beginning of High School Period
- a. Physical, emotional, and intellectual signs of femininity or masculinity
- b. Relation of increase of weight, stature, and mental development
- c. Hyper- or hypokinetic
- d. Signs of rational self-confidence
- e. Plenty of reserve energy (physical and mental) or easily fatigued?
- f. Tendency to face squarely or to dodge critical situations
- g. What is the character of reaction to unpreparedness or to unequalness to a given situation?
- h. Special interests and aptitudes

III Entrance to College or University
- a. Relation of weight, stature, and mental development
- b. Pronounced masculine or feminine qualities
- c. Purpose stated by student for entering college
- d. General mental attitude towards life
- e. Evidences of emotional stability or instability
- f. Signs of healthy independence
- g. Ability to observe and to record observations as well as to ask pertinent questions
- h. Control exercised over wishful-thinking
- i. Appreciation of emotional and mental qualities essential for culture
- j. Defense reactions to compensate for inadequacy

This inventory of the educational capacity and progress at three important epochs should be taken in the case of every student, and without at least the information asked for in this questionnaire it is ridiculous to make an attempt to direct the activities of students intelligently. Any so-called process of education which does not take cognizance of even elementary biological facts is nothing more than a clumsy attempt to assist students to bungle through life.

At the beginning of the school period it is important to note the general physical and emotional characteristics of the child. The comparison of the information obtained at this time with that obtained later in regard to these traits would be useful as a means of measuring the process of development and the success of the scholastic training.

With children at this time it is particularly important to note whether they have the capacity to stand and sit quietly or whether they are fidgety and restless. Those who do show signs of motor restlessness demand special care. A great deal of valuable information can also be obtained from noting the precision and coördination of the spontaneous and voluntary movements, as it is generally recognized that the motor adjustments play a very important rôle in determining the direction and character of the conscious processes. Important information is often supplied merely by noting the carriage, facial expression, and general attitude of a person.

A teacher should try to find out as quickly as possible by what avenues a child takes in impressions—by eye, ear, or by the assistance of the muscular system. Many children seem to be stupid merely because they are visualists and respond slowly to auditory stimuli, and often the reverse is true.

One of the unfortunate effects of the present academic type of education is to make it difficult for children to preserve a spirit of intelligent curiosity. The signs marking the existence of this very desirable mental attitude should be carefully noted with a view to its cultivation and not, as is usually the case, to its repression.

The question of fatigue, both physical and mental, is an extremely important field of investigation. A great many people go through life with their adjusting capacity seriously impaired by having crystallized the fatigue habits formed in school. Children should never be allowed to work after the evidences of alertness and freshness have disappeared. Bad mental processes may be formed and become permanent habits as the result of working in poorly ventilated rooms, or in struggling with lessons after the fatigue symptoms have developed. Note should also be made by the teacher not only in regard to the evidences of fatigue appearing in the class room, but in regard to the fatigableness when pupils are engaged in sport.

The signs of unusual and capricious development should receive careful consideration and special treatment.

When we come to the beginning of the high-school period, these observations should be continued and supplemented by others, giving an indication of the rate and character of the child's development. At this time it is very important that some record should be made of the physical, emotional, and intellectual signs of femininity or masculinity. These observations are important since they give an indication of whether biological development is proceeding along normal lines. Many parents and teachers do not appreciate the fact that boys and girls who do not develop the pronounced traits of their sex begin unconsciously to effect some kind of compensation. Only a teacher who possesses healthy qualities of mind and body as well as plenty of good common sense is competent to assist young people to attain the right kind of compensation—one that will not result disastrously as the result of some strong emotional crisis. The teacher should be keenly alive to the problems connected with the development of the emotional life at this period and supplement the instruction in sex hygiene given in the home, not leaving anything to be supplied by imagination, and by the judicious presentation of facts forestall the unfortunate results of half-truths picked up at random, which have such a disorganizing effect upon the personality.

The development of the signs of rational self-confidence should be carefully noted, and if there is a tendency to self-depreciation or overestimation, steps should be taken at once to remedy the defect.

During the high-school period a comparison should be made with the degree of physical and mental fatigableness noted during the earlier period. During puberty, in order to detect the first signs of imperfect emotional adjustment, the general attitude of the young person towards life should be observed and attention paid to whether critical situations are faced squarely or whether there is a tendency shown to avoid whatever is annoying or unpleasant. Some record should be kept of the increasing preparedness to meet life as it is and the nature of the situations which are met and overcome with vigor and frankness, as well as those that give rise to per-

plexities and embarrassment. At this time the special interests and aptitudes should be so well marked in the majority of cases as to give some clue to the lines of work to be followed in later life.

Upon the entrance to college or the university, these records are still further supplemented, and the comparison of weight, stature, and mental development at this period with the two preceding ones often leads to interesting deductions. Every student, upon entering college, should be asked for a plain, straightforward, concise statement of his reasons for wanting to go to college. The character of the replies in the majority of cases will indicate whether a dominant purpose is present in the mind or whether the applicant is merely drifting down the educational stream and is following the conventional course. Much more important than the information generally obtained from examination papers is the light thrown upon the student's ability to observe and to record his observations as well as the ability to ask pertinent questions. If there is a spark of creativeness left, it can be much more easily detected by the use of biologic methods of examination than by the results of the usual formal examination.

A trained examiner would not find it difficult to estimate at this time in a general way to what extent wishful-thinking dominates the personality of the student. Is there a tendency shown to replace actual situations by imaginary ones? If there is, then it becomes necessary to determine to what extent this process is the result of a healthy imagination or of desire to substitute only pleasant and comforting situations for those of the dull grind of everyday life.

The student's interest in and understanding of the nature of culture may be readily guaged by ascertaining whether there is an appreciation of the emotional and mental qualities essential for establishing and maintaining a well-balanced personality. If the balance of the personality is disturbed, then care should be exercised in determining the nature and extent of the compensatory reaction.

Opportunities should be supplied in our universities, and particularly in the medical departments of those universities, for training teachers competent to make these inventories, which will make it possible for parent and teacher to ascer-

tain whether the child is securing at least the bare essentials of an education.

If the public were educated to the point of expecting that one of the first and chief duties of the teacher was to estimate the adaptive capacity of the child, a new stimulus, interest, and dignity would be given to the teaching profession. It requires far greater breadth and depth of knowledge and a better rounded personality for a teacher to be capable of assisting in preparing a student for successful development in living than it does to prepare him for business, a profession, or a scholastic career.

Provision should be made in clinics and dispensaries for giving instruction to teachers in the art of analyzing the personality and in discovering the forces at the foundation of character. Incidentally it is worth mentioning that assistance could also be given to instructors in the medical schools in learning something about the difficult art of teaching, as well as in stimulating their interest in the general problems of personal adjustment.

The teacher's influence in national life was eulogized by Von Moltke, who declared that the Prussian schoolmaster had won the Franco-Prussian War. The Prussian teacher undoubtedly gave great assistance in establishing and maintaining an autocratic form of government and in the preparation for war. Will it be possible in a democracy to develop a type of teacher superior to the Prussian type and better qualified to promote the conditions essential for a just and lasting peace? Democracy has not by any means proved that in all respects it is superior to other forms of government. We should accept the fact that democracy is now on trial and try to make the democratic system safe for the world by finding out what the essential factors of temperament and character are and then directing these forces intelligently, so that full expression may be given to normal, well-balanced personalities. The success and interest developed in establishing the foundations of democracy may be pretty accurately measured by showing that we appreciate that education should be a process of assisting a person to adjust life happily and successfully. Once this biological view is accepted, the teacher becomes a recognized leader in a movement upon the success of which the safety of our civilization depends.

TRADE UNIONISM AND TEMPERAMENT*

Notes Upon the Psychiatric Point of View in Industry

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THE philosophy of trade unionism is yet to be written. Its history is acknowledged to be in many respects baffling. Its present status deserves no other term than "hectic," and its future seems at first sight quite beyond prophecy. In the first place, we may observe, there are many trade unionisms rather than any single trade unionism; but whether there are one or several separate trade unionisms, no doubt most observers would regard the trade unions as a phase rather than an end, as a technique rather than a purpose, sociologically considered. I was led to the present reflections while trying to clear the way for concrete work on the mental hygiene of industry.

Under the auspices of the Engineering Foundation, certain workers have recently been trying to discern whether the principles of mental hygiene could not be applied with some reasonable hope of success to the problems of industry. Now the tools of the mental hygiene movement—that is to say, the mental hygiene personnel as so far developed—fall into at least three groups: (a) a group of psychiatrists, (b) a group of psychologists, (c) a group of social workers; and in point of fact a few psychiatrists, a good many psychologists, and a number of social workers with more or less mental hygiene training are already at work under various auspices in industry. It is not my task here to speak of the beginnings and progress of that work, summed up recently in a paper by Dr. Stanley Cobb of the Harvard School of Industrial Medi-

* This paper was read at the opening session of the Third Convention of Societies for Mental Hygiene, held at the New York Academy of Medicine, New York City, February 4, 1920. It represents a study made in connection with a research undertaken by Dr. Southard for the Engineering Foundation of New York and was the last paper read by Dr. Southard. For Dr. Southard's preliminary report on this research, see *The Movement for a Mental Hygiene of Industry*, Mental Hygiene, Vol. IV, pp. 43-64, January, 1920.

cine, entitled *Applications of Psychiatry to Industrial Hygiene,*[1] and by myself in a paper entitled *The Movement for a Mental Hygiene of Industry.*[2] In the present communication I wish to speak in a narrower sense—i. e., excluding psychology in its technical sense—of *industrial psychiatry*—that is, of the psychiatric division of mental hygiene and the possibility of its application to a leading problem of industry—namely, trade unionism. "Industrial psychiatry" is itself no new topic. The phrase was perhaps first used by Irving Fisher, Professor of Political Economy in Yale University. But the idea that the psychiatric point of view might profitably be applied to industry has become almost a popular idea with the publication of *An American Idyll,*[3] the remarkable biography of the late Professor Carleton Parker, of California and later of the State of Washington, by his widow, who has carefully noted the progress of the psychiatric idea through Parker's independent thinking and personal contacts with American psychiatrists. In short, there has been a much more sudden and productive pooling of psychiatry and economics than either mental hygienists or sociologists could have hoped.

But is such a union of mental hygienic and sociological interests as that foreshadowed by Carleton Parker likely to be early fruitful? After all, with the genius of Carleton Parker or even with the access of many talents into the field, are we not dealing with pious hopes rather than with productive conclusions? I am afraid that a good many practical business men find little to hope for and much to fear in any collection of theoretical ideas that we may tie together with the name *"ology"* or in any movement of the world dignified by the suffix *"ism."* Ologies and isms, the practical business man once might have risen to remark, have no place in American practice; to-day he knows that he should know better. The close relation of ology to ism in practice is well enough shown even in Marxian socialism. There seems to be no doubt that Marx got many of his ideas from the German philosopher, Hegel, and many others from the French social philosopher,

[1] *The Journal of Industrial Hygiene*, Vol. I, pp. 343-47, November, 1919.

[2] See footnote page 281.

[3] *An American Idyll; the Life of Carleton H. Parker.* By Cornelia Stratton Parker. Boston: The Atlantic Monthly Press. 1919.

Saint Simon, and even some from the English economist, Adam Smith, and the followers of Adam Smith. The comprehensive history of European thought written by J. T. Merz[1] speaks of Marxianism as a kind of materialistic paraphrase of the philosophy of Hegel and regards the materialistic results of Marx as working directly into the hands of the German historical school of political economy and jurisprudence. Herein socialism, a popular movement, has in turn influenced sociology, a theoretical science.[2]

A great many reasons, good and bad, have been given for the Great War, and there are even more predictions for the future of reconstruction than there have been explanations of the Great War. But whether we charge the receding terrors of the war or the febrile difficulties of the present to the bad morals or the faulty education of the people themselves or of their leaders, whether we regard the situation as good or ill in the hands of the slowly developing juristic system that wavers between excessive social control and excessive individual liberty, or whether we throw the whole onus upon the shoulders of blind economic development, we should make a bad error if we left theory, science, and philosophy out of the account.

It has struck me that one of the nearest duties of the Engineering Foundation, in undertaking work upon the mental hygiene of industry, is to carry the banner of theory rather more proudly than it is sometimes carried. I suppose practitioners of any art or science are rather apt to regard the practitioners of some other art or science as petty, theoretical,

1 Merz, John Theodore. *A History of European Thought in the Nineteenth Century.* Edinburgh: W. Blackwood and Sons, 1896-1914.

2 That ologies can influence isms is shown in two other examples that may be borrowed from Merz's analysis. Fichte, in some ways the most German of philosophers, in 1800 wrote a short treatise called *The Closed Industrial State*, and in 1826 the independent landed proprietor, Von Thunen, wrote a somewhat similar work entitled *The Isolated State with Respect to Agriculture and Economics*, giving algebraical formulæ for the natural wage of labor by eliminating rent. I commend to every reader the tenth chapter of Merz's work entitled *Of Society*—especially any reader who doubts the relation of theory to practice in the development of the present human situation. Written as it was before the Great War (the fourth volume was published in the year 1914), this work gives the most comprehensive brief account of the total situation that we now possess.

speculative. The sort of question that the representative of one science puts to the representative of another is in nine cases out of ten the unanswerable question. "Why don't you do something to cure rheumatism?" the physician is rather apt to be asked by his grandmother, or by his friend the lawyer or the engineer. If the question were turned about, and the grandmother were asked why she had not provided a better grandson, she might well reply that the science of eugenics was very young in her time. If the physician should ask the lawyer why the jurist could not make laws that would fit the individual more neatly, he would be met by silence and an injured look. Likewise the engineer would be apt to beat a silent retreat if some one were to ask him why his ventilating systems would not work more accurately than modern mental tests.

But the engineer is no doubt a step ahead of the business man in the street. The engineer, especially the modern personnel manager, is no doubt most receptive to whatever his colleagues from other arts and sciences have to bring. For my part, I look to no concrete results from those widely advertised industrial conferences held in our country in the latter part of 1919, simply because management and the engineering profession in all its branches were, in so far as I could make out, not properly represented. Capitalists who have once been engineers are capitalists notwithstanding. Labor leaders are prejudiced, and no doubt rightly so, for the practical purposes of their leadership. The public has interests that are diffuse rather than concrete and has no specialized knowledge either of financial systems and conditions of labor or the theory and practice of management. But when the over-conservatism of Capital and the over-radicalism of Labor and the nebulous vagaries of the Public have failed, as they will surely fail, to solve the industrial problem, then will be the time for engineers, in the broadest sense of that term, to be thrown into the game.

But expert engineers who make the wheels go round are not quite so authoritative when it comes to questions of the wheels themselves: Shall the wheels be turned at all? At what rate, and especially what new wheels shall be called into service? I spoke above of the causes of the Great War as

possibly lodging in a faulty education, in evil morality, in a jural system falsely evolving, and in purely economic developments. The problems of reconstruction may well betake themselves to the same arts and sciences. The problems of reconstruction are likewise possibly mental, possibly moral, possibly incidental to adjustments of government and law, possibly under the influence of economic laws, old or new. It will be the duty of engineers facing industrial problems to deal in no narrow spirit with those problems and to bring more than mere technique to bear upon them. The problem is beyond the grasp of scientific management except in some other, broad interpretation of that term, which no one would be likely to accept. No mere education of expert managers, of workmen, of the public, or even of the capitalists themselves is likely to work, because the problem digs morally far deeper than education within the grasp of the much vaunted modern publicity method.

But although the problem is not one of scientific management, neither is it one to be solved bodily by the methods of charity and welfare. Not happiness, but justice, is the cry to-day. The representatives of scientific management must come together with the representatives of social welfare. Those who stress the mental element must pool their proposals with those who stress the moral element. And both the efficiency engineer and the expert social worker must bear in mind the cry for so-called social justice. Those who raise this latter cry seem always in some sense to rely upon improvements in government and law, whether those improvements are such as to make us have "faith in Massachusetts" or such as hearten the legions of Bolshevism. The spokesmen of representative government in America or the Soviet system in Russia would nowadays both claim with equal vivacity that they were out for social justice. Legislators in America and officials of the Soviet system in Russia and all intermediate types of politicians not only argue for social justice, but would resent the statement that the principles of organized welfare work, and in the end also the principles of scientific management, would not be successful at all alongside of and even by virtue of the principles of social justice.

Thus we have no doubt advanced appreciably from the

standpoint of Karl Marx. Karl Marx stood for self-help on the part of the scientists. There was no immutable principle of natural justice which would save the workmen. They would have to help themselves. As Sismondi cried, "What! Is wealth, then, everything? Are men absolutely nothing?" Marx's facts, such as they were, seemed to have been derived from Adam Smith, from Ricardo. The statisticians had built up that fabulous, but rather harmless creation "the average man;" Ricardian economists then got up something which proved to be more of a Frankenstein—namely, "the economic man." The theory of wealth upon its tripod of wealth, wages, and profit was the result of British economic thought. The economic man was a machine upon the Ricardian theory, and it was against this mechanical idea of the worker that Carlyle inveighed and Karl Marx leveled his suggestions for a complete overturn of the social order.

I am inclined to see, in the great movements for scientific management, for social welfare, and for social justice, the best efforts of the Head, the Heart, and the Long Arm to solve the problem. Of course we must not charge the Ricardians of old, any more than a member of the Taylor Society of to-day, with delusions in human sympathy, and no doubt the movement for scientific management, in its modern aspect, has made much room for the moral motive, particularly in its study of the fatigue factor in industry. Again, it would not do to charge Carlyle of old or Jane Addams of the present day with irrationalism, or with a tendency to behead the system and run it by means of a heart only. As for the representatives of the Long Arm of the law, I am less willing to name names either in New York or Petrograd because I myself, not being a lawyer, entertain a wholesome respect for the powers of the Long Arm. Nevertheless, among the most liberal jurists whom I have had the pleasure of listening to, I fancy that none want to acknowledge the desire either to behead the social animal or to tear out its heart. To be sure, if one took the principles of Austinian jurisprudence quite literally, the Long Arm and even the Big Stick are its most obvious forces. "As to a command of the law," says Austin, "the person to whom it is directed is liable to evil from the other

in case he comply not with the desire." "Command" is certainly the key word of Austinian jurisprudence.

You will rightly say that I have wandered far from the topic of trade unionism and temperament. My set purpose in this wandering was to show that a great series of noble endeavors have quite failed to solve the industrial problem. I am afraid that some economists, both followers of Marx and ardent scorners of him and of his works, are still inclined to think that economics might well be left to solve its own problems as the blind were once commended to a system of representative leadership by other blind who, let us hope, had a strongly developed six sense. But the Great War and the problems of reconstruction do not argue strongly for the program to let things stew in their own juice. Neither the *laissez-faire* plan of letting things go their own gait nor the neat, rounded little Utopian systems of one or another economical theorist work practically.

Accordingly the Head, Heart, and the Long Arm of science tried their luck. Scientific management, social welfare, and social justice became bywords, each accomplishing something or a great deal according to the times and seasons. One great profession, that of medicine, had no share in these matters unless very indirectly by influencing the university teaching of men of science, moralists, and lawyers. To-day we see signs that medicine is to be called in at least upon daily aspects of the problem. We cannot otherwise explain the numerous increases of interest in industrial medicine shown in more than one country and by more than one type of agency, official or voluntary, in our own country. Departments of hygiene throughout the country are securing important contacts with industry, either solving the problems derived from the works or carrying new laboratory results back to the plants themselves or in a few instances laying down programs for aid in the personnel problem.

Writing as I am to-day for a group of psychiatrists and others to be shortly gathered for the Eleventh Annual Meeting of the National Committee for Mental Hygiene, I want to make a plea for the inclusion in the programs of industrial medicine of the neglected field of mental hygiene. I want to call attention to the fact that the Engineering Foundation,

representing United Engineering Society, has taken up concrete beginnings of research upon this problem of the mental hygiene of industry. It seems to me that, with a fair fortune, this work will so develop that industry will shortly demand from the psychiatric branch of the medical profession various consultants who will not do their duty either by medicine or by psychiatry if they do not look attentively into these new matters.

I think the ordinary physician, even the industrial physician, would look upon the topic of trade unionism as very remote from his interest or knowledge. I am afraid that most mental hygienists would feel themselves wholly at a loss confronting trade unionists. Certainly trade unionism is a system or a movement. The psychiatrist would probably concede that he was as able as any one else to evaluate the trade unionists who might consult him for his soul's sake. But if, in the administration of what used to be called the "talking cure," the psychiatrist had to listen to much talk about trade unions, he would doubtless close his own book in despair.

Nor will I want to make extravagant claims for mental hygiene or its personnel. The problems which mental hygiene will attack are practical problems, and no practical problems would ever solve—so far, at least, as they deal with individual situations—in camera. But nevertheless I think mental hygiene might have something to say in many problems. Who would say, for example, that in the Great War Bolshevism was not a topic whose complete history will never be written without a thorough account of the psychiatric thread running through it—that is, the psychopathic personalities that have either caused or contributed to the Great War and to Bolshevism?

Let us take the late Professor Hoxie's work, *Trade Unionism in the United States,*[1] published in 1917. Hoxie, according to his introducer, Dr. Downey, was originally trained in the "straitest sect of cloister economics" and was very able to "sharpen a keenly analytical mind upon the subtleties of marginal utilitarianism." He then fell, according to Downey,

[1] *Trade Unionism in the United States.* By R. F. Hoxie. New York: D. Appleton and Company, 1917.

under the "potent spell of Thorstein Veblen." Thereupon Hoxie spent more than ten years in intensive study of American trade unionism, which led him into various fields of inquiry, such as wage theory, socialism, pragmatic philosophy, social psychology, employers' associations, scientific management. His work on *Scientific Management and Labor*[1] is well and favorably known.

I want especially to speak of Hoxie's theory of the four functional types of trade unionism in America; but to give some idea of Hoxie's methods at the same time and point out some relations of this work to mental hygiene, I propose to list a number of items taken from the report of Hoxie's students upon the trade-union program. This program (embodied in Appendix 2 of *Trade Unionism in the United States*) fills between eighteen and nineteen pages. From Section I, the items entitled *Aims* may be quoted:

Expression of the self—personality, temperament, group philosophy.
Higher intelligence and capacity for enjoyment.
Looking to improved conditions—more now.
Improvement of working conditions in the matter of: wages, hours, safety, health, security, continuity, exertion, independence and personal dignity, supervision and control.
Improvement of living conditions and standard of living: uplift of the working class; uplift of the community as a whole; self-help.

From Section II, *Principles and Theories,* may be quoted:

Essence of social maladjustment is the wage system.
Low wages cause of most human ills.
Belief in the wage fund theory (or lump of labor theory) causes opposition to industrial schools and immigration.
All workers are of the same benefit to society, whether skilled or unskilled, and all should therefore receive the same wages.
Competition between man and man is healthy; between man and machine it is injurious to man.
Society's obligation to the worker is to help him obtain his rights, including the right to leisure and right to education.
Organization is essential to freedom from oppression.
Cheap workmen's hotels, minimum wage, etc., simply retard the one right way to better things—organization.
Might is right (when Unionists win).
Right and justice are the rules of the game of the ruling class.

[1] *Scientific Management and Labor.* By R. F. Hoxie. New York and London: D. Appleton and Company, 1918.

Unions justified for the good they do, no matter how great the corresponding damage.
Ends justify the means.

From Section III, *General Policies,* may be quoted (very few items from this section have direct mental hygienic interest):

Organization for mutual insurance.
No affiliation with welfare plans of other groups.
To act pragmatically and opportunistically, making use of:
- Self-help only
- Monopoly and strategic position
- Strikes
- Boycott
- Violence if necessary
- Methods "within the law"
- Mediation, arbitration, and conciliation.

To maintain efficiency and high moral character.
To encourage industrial education.
To use direct action:
- Sabotage
- General strike
- Violence.

To discountenance violence.
To use any method in a pinch.
To educate and uplift the union personnel.

From Section IV, *Demands,* a few items may be quoted:

Equal pay for men and women.
No piece work.
Abolition of "rushers" and "speeders."
No scientific management.
No changes in classification.
Protection against occupational diseases.
Sanitary shops.
Abolition of child labor and night labor.
Regulation of hiring, discharging, fining, docking, promotion, and settlement of disputes.
Legislative demands:
- Prevention of stop-watch, high-speed schemes
- Workmen's compensation
- Old-age pensions
- Public as against private welfare plans.

From Section V, *Methods:*

High moral requirements for membership.
Violence.
Intimidation of employers.
Intimidation of scabs.
Sabotage.
Education work through:
    Emotional appeals to public
    Education of the public
    Inconvenience of the public.
Social ostracism.
Mutual aid and insurance.
Grievance boards.
Moral suasion.
Control through superior competence and efficiency of union labor.

Practically the whole of Section VI, *Attitudes,* might well be quoted, since almost every item has some relation to mental hygiene:

"Moral and educational worth, not wealth, the standard of human greatness."
"Physical power the motive force of everything; might is right."
"The Church and the State—the great pillars of the capitalists and of capitalist society."
"The contented workman is a pitiable object. Think of a smile in chains!"
"Those who 'kick' without reason are better than those who do not 'kick' at all."
Employers can meet with workers on a basis of justice to both.
"Contracts with employers are not sacred."
"Every welfare plan has a joker in it."
Conflict between materialistic majority—"Bread and butter unionists"—and the idealistic members.
"Trade unionism—the bulwark of capitalism."
"The A. F. of L. is not a labor organization; it is simply a combination of job trusts."
"When a man gets too wild for the A. F. of L., he goes to the I. W. W.; so the I. W. W. is a good thing."
"A man is a scab when he gets in the way of your job, no matter how badly he needs the money."
"Men's unions have bosses; women's do not."

All the above mass of various and even contradictory statements about unionism would form much grist for the psy-

chiatric mill, as I think every psychiatrist will agree. The point of view of mental hygiene certainly needs to be applied to industry if such analyses of Hoxie's students are at all representative. The insight of Carleton Parker is certainly justifiable.

Perhaps the most interesting contribution of Hoxie's work is his distinction of five functional types—four, if we exclude the group of so-called dependent trade unionisms which rely upon the support of other forms of unionism or are "yellow" in the sense of being created by employers themselves. These four main types of unionism are:

Business unionism
Uplift unionism
Revolutionary unionism
Predatory unionism

I quote from Downey's summary of these forms (p. 17):

"*Business unionism,* accepting the wage system as it is, seeks the best obtainable terms of employment for its own membership. Its method is collective bargaining supplemented by mutual insurance and occasional resort to strikes; its outlook is that of the craft or trade, its aims are somewhat narrowly economic. The railway brotherhoods furnish the stock illustration, though the type is dominant in the American Federation of Labor as well. *Uplift unionism* accepts, along with the wage system, the whole existing social order. Its mission is the diffusion of leisure-class culture and bourgeois virtues among the workers. Mutual insurance is its main function and homiletics its preoccupation. There is no representative of the pure type—unless the Woman's Trade Union League be accepted as such—but there is a strong infusion of uplift idealism in most unions that are dominated by the business aims. *Revolutionary unionism* avowedly aims at the overthrow of the existent socio-economic order by and for the working class. Its two variants—socialistic and quasi-anarchistic—are sufficiently represented by the Detroit and Chicago organizations of the I. W. W. *Predatory unionism* practices secret, rather than open, violence. It is lawless, and in so far anarchistic, but it professes no far-reaching philosophy, nor does it aim at anything beyond the immediate

economic advantage of its own membership. When this ruthless policy is a counsel of despair, the continuation of a bitter struggle which has gone against the union and the practical answer to a policy of extermination on the part of employers, Professor Hoxie terms the resultant subspecies *guerilla unionism*. The dynamiting career of the structural iron workers is a familiar example. When, on the other hand, predation is deliberately adopted for the aggrandizement of a narrow ring, he applies the more opprobrious epithet of *hold-up unionism*. The term is not altogether happy. Cunning characterizes the type still more than force; its most brilliant successes have been gained by illicit alliance with monopoly-seeking employees. 'Skinny' Madden and 'Sam' Parks are the beaux ideal of the type. It is fair to add that predatory unionism, in both its forms, is more picturesque than significant."

Assuming that the late Professor Hoxie's account of the functional types of trade unionism is approximately correct so far as it goes, let us see whether the psychiatrist can find any grist for his mill in an endeavor to discover what these functional types of trade unionism might mean in terms of the great fundamental psychic trends.

Trade unionism looks like a phenomenon of mass psychology. No doubt the final account of trade unionism will be in terms of mass psychology, but at the present day we do not know too much about this so-called mass psychology. Moreover, it might be dangerous to apply modern and incomplete ideas of mass psychology to a social problem so red hot as the trade unionism of the present day. Very near to the surface of the modern psychiatrist's consideration of any problem of to-day is the question of temperament. What temperament may mean in terms of mass psychology is, to say the least, doubtful. We can serve ourselves best with the distinctions of the psychology of the individual, simply because we have no mass psychology in the matter of temperament. Granting that Hoxie was right in his definition of the functional types of trade unionism, may we not profitably inquire how his results fit with what we know of temperament? I shall shortly be able to show that the four main types of trade unionism discussed by Hoxie correspond rather

neatly with the classical types of temperament. Let me insist, however, that my point is not in the first place to say that trade unionists of one functional type are all temperamentally equipped in a certain way. In the second place, there is no question whatever that labor leaders in a given way are necessarily men that would prove to be the vehicles of a particular temperament. Nor in the third place is it at all certain that the founders of particular trade union tendencies are pure examples of a temperament corresponding with their particular unionism. I am rather inclined to think that evidence will be forthcoming to prove that the genesis of the different trade unionisms is due in great measure to certain temperamental trends; but there is here no question of historical proof, since my own point lodges in this: that the psychiatrist has a method and a point of view in the study of so intricate a problem as that of trade unionism.

I did not trust to my own analysis of trade unionism, since indeed I had no special claim to training that would fit a man for such analysis. Likewise, I shall confine myself to the safe ground of a very ancient account of the temperaments. The psychiatrist cannot help having personal, and even partisan and political, views of a topic like trade unionism. The psychiatrist, like any other citizen, might therefore import his own private views into the analysis.

Without further preface, let us consider the classical temperaments as they have descended to us from Hippocrates and Galen. The "temperaments" of these Greek physicians were in the literal sense humors and the terms "good humor" and "ill humor" have come down to us at the present day as a result of Hippocratic and Galenical ideas. These men had insight and hope, and were, as we say, humorists. They caught the right emphasis, as the modern work upon glands of internal secretion seems to show. However, they were of course, in the detail of their analysis of humors, wrong enough. They distinguished the following four types of temperament: the phlegmatic, the sanguine, the melancholic, and the choleric. These Latin equivalents for the Greek terms are embedded in the European languages and still used in the English language for temperamental situations roughly corresponding to what Hippocrates and Galen described.

We distinguish sharply the power of a man's intake and sensory stimuli from his motor power of responding in various ways to these stimuli present or past, but between a man's intake of stimuli and his discharge of responses man, in common with the higher animals, interposes, as we currently say, his intellect and his emotions. The intaken stimuli are somehow regarded and combined in the mental processes termed intellectual—that is, inter-ligating. The behavior of man—that is, the shape his responses, muscular and glandular, take—is thus not merely a matter of his senaory intake of stimuli, but also a matter modified by memory, imagination, and other intellectual combinations. Moreover, besides sense, intellect, and will—to use the old terms for these functions—we have also to deal with a man's emotions, which may influence his behavior essentially and sometimes almost regardless of his sensory intake, his intellectual combining power, and even the natural lines of his motor responses. There is an attitude of pleasure, pain, and perhaps of emotional indifference which modifies behavior. These are very inadequate words in which to describe what a man does as modified by what he takes in, mulls over, and has pleased or pained feelings about, but these over-simple words will serve for the moment to make my point that sensory and motor power on the one hand are apparently much more than the intellect. With the same senses, perhaps with the same muscles and glands, and no doubt with the same brain equipment, two men might act differently. We should be inclined to ascribe these differences to temperament. We might seek the causes of temperamental differences in the various juices that bathe the organs of the body, including the brain; but these matters do not here concern us, since our main point is that temperamental differences of one sort or another have been recognized since early Greek medical thought.

Thus, if we are analyzing the trade unionisms from a temperamental viewpoint, we are not discussing how logically well or ill contracted these trade unionisms are—that is, their intellectual value in the logical world—nor are we discussing their values in behavior except as behavior is influenced by temperament. Let us now show the four trade unionisms that

were above briefly summarized. The parallel columns will appear as follows:

Classical Temperaments	Functional Trade Unionisms
Phlegmatic	Business
Sanguine	Uplift
Melancholic	Revolutionary
Choleric	Predatory

There are obviously certain logical results between the ideas conveyed by the terms for temperament and the terms for unionism. I do not need to draw out in detail the suggestion that the phlegmatic temperament of relative indifference to pleasure or pain of ordinary degrees is precisely the everyday temperament of the majority, not only of laboring men and all labor leaders, but also of all people in general. From business unionists in Hoxie's sense, as from all persons with the phlegmatic temperament, we may expect businesslike reactions, with not too much color and not influenced by the extremes of temperament. In accordance with the warning expressed above, I do not wish to say that business unionists may not now and again vivaciously, melancholically, or vituperatively argue their points, but the logical machine of the business trade union in Hoxie's sense appears to be a machine in which vivacity, melancholy, and irascibility are not effective forces. We do not regard the esteemed leaders of the American Federation of Labor as swayed by their different logical considerations, since we concede their proper partisanship for the men they represent.

As Hoxie sufficiently indicates, the uplift phenomena of unionism are still well-nigh universally displayed by the various types of craft and industrial unions. Perhaps there is no single actual union that expresses uplift and nothing but uplift in its work. Can we not safely conclude, however, that something like what underlies the sanguine temperament underlies the uplift movement? The modern psychiatrist would have to say concerning sanguine persons that they are often subjected to an opposite feeling—one of the blues. Many such persons, technically called cyclothymic, belong by temperament to the uplifters. Whatever and whoever demands uplift gets the proper sympathy of these persons.

whose interest may shift from week to week and month to month from one proper object of sympathy to another equally proper object. Perhaps we owe much of our effective social-welfare work to the existence of the sanguine in the world. Not even their blues, or what were originally called the blue devils, remain valueless, since on the upswing of their temperament they depict in glowing colors the terrible things felt by them when possessed of their devils.

Each of these temperaments, the phlegmatic and the sanguine, has its peculiar virtues. Each of us has felt both trends at different times. Is it not of practical social value to bear in mind the possibilities of these trends, to evaluate not only other people's, but one's own temperamental trends in this way?

Perhaps the least obviously effective comparison here made is between the so-called melancholic or atrabilious temperament and the revolutionary type of trade unionism. There is no neat correlation between black bile and the I. W. W. or the I. W. W.'s quasi-anarchistic forms of unionism. However, there is some suggestion of a parallel in the mental attitude of the revolutionary and that of the confirmed melancholic. The confirmed melancholic, particularly of the more advanced years, is apt to center thought upon certain ideas which in frank cases of mental disease may amount to delusions. The point that we outsiders must bear in mind which might concern the revolutionary types of trade unionism is not their advocacy of direct action, sabotage, or violence, but the grounding of all their lives upon definite ideas or hypotheses. The emotional tone of the revolutionary is almost always unpleasant. They are almost always in the state of felt passivity. The passivity they feel simply illustrates for them the passivity in which they conceive the world, especially the industrial world, to be. It seems to me that if we approach the analysis of these revolutionary unionisms with the idea of their actual grounding in unpleasant violences and violences of felt passivity, we shall get on much better than if we tried to interpret their behavior along simple lines of direct action. The direct action advocated by Sorel[1] in his

[1] Sorel, Georges. *Reflections on Violence.* Authorized Translation by T. E. Hulme. New York: B. W. Huebsch, 1912.

classical work on violence is a type of behavior grounded in an hypothesis philosophically held. We can best explain the theories of Sorel on temperamental grounds, and this entirely aside from the logical accuracy of his conclusions. For aught we know, one or more of the revolutionary types of trade unionism may be logically quite sound. Our one concern, as psychiatrists, from the present plan down would be to appraise correctly the share of temperament in the total response or line of behavior taken by the revolutionary under examination—e. g., by the philosophic syndicalist, Sorel. Without stopping to inquire whether Hippocrates and Galen would concede our modern analysis of the melancholic temperament to be a correct one from the point of view of Greek medicine, let us concede that at all events there does exist a type of revolutionary temperament of unpleasant feeling-tone and of a felt passivity quite capable of explaining many proposed revolutionary programs.

Far easier is it to see the choleric temperament in the so-called predatory trade unionisms. Here are men working, not upon the comparatively high intellectual levels of the revolutionary unionists, but upon lower instinctive levels. The revolutionary and the predatory unionist may advocate and perform the same acts of violence and sabotage. The revolutionary will have his reasons; the predatory will act on impulse. The revolutionary will have a predominating emotional tone of unpleasantness and will feel decidedly in the passive voice, like many a victim of out-and-out delusions. The correctness or accuracy of his belief makes no difference to his temperament. The felt passivity may be actual passivity or a fancied passivity. The effect upon the revolutionary's behavior is the same whether the felt passivity is real or imaginary. On the other hand, the predatory unionist may well feel himself frankly and gloriously in the active voice. His emotional tone may be unpleasant enough, though most of us would acknowledge in the midst of anger a certain pleasure. However, the predatory unionist, like any impulsive predatory person, is not a very pleasant fellow on the whole, either taken from the inside or from the outside.

I do not know how sound these parallels between the ancient temperaments and the modern unionism types may

seem. Upon some such lines, however, I am convinced that we shall learn to distinguish not only the functional types of trade unionism, but also among other types that function in the modern world. We are very far removed from the average man of the French statistician, the economic man of Ricardo and his abysmal failure. The world looked for many years for statistical resemblances amongst men. We should now look for qualitative differences. If it should turn out that Hoxie has made a fundamentally accurate study of the types of trade unionism, no doubt the analytic point of view of modern psychiatry may be of considerable help in the further study of these trade unionisms. We may safely leave to the logical historian the appraisal of the accuracy and practical worth of the ideas and trends that underlie such developments as those of trade unionism. The psychiatrist may not be sure that Hippocrates and Galen were more than approximately correct in their account of the temperaments. The modern psychiatrist may be able to add a little here and a little there to the classical doctrine, or he may be able to overthrow the classical distinctions altogether. But upon some such analytic line shall he be able to help the world in its confrontation of many problems. It will not turn out to be a matter of the Head alone—that is, of a particular logical and scientific evaluation of the proposed system; it will not turn out to be a matter of the Heart alone—that is, a matter of social welfare, rose-tinted or morocco-bordered by the temperaments of uplifters; and it will not be a matter of the Long Arm of the law until the law, so to say, can tell its left hand from its right—distinguish individuals from one another more adequately than its general relations now permit. In short, the individual categories of medicine—the art which of all arts has from the beginning taken the individual as its object—will, we hope, be of some service to the world in such complicated fields as that of trade unionism. Mass psychology and mass psychiatry may be a thing of the future of undreamed-of proportions and quality. We have only the minds, normal and abnormal, of the individual man to go upon. Can we discern in the nebulous and mobile outlines of trade unionism, once more recurrent, the classical trends of temperament? If we can be sure of our analysis here, we can no

doubt meet the problems of trade unionisms with much more understanding and with very much more sympathy. The mental hygienists, I venture to say, as represented both by psychiatrists and by psychologists, will have in the long run a considerable contribution to sociology. Out there we speak in terms rather of dreams than of performance, but for that matter the trade unionisms are themselves no better off in this respect; nor has the Head, with its scientific management, the Heart, with its welfare program, and the Long Arm of the law, with its ideal of social justice, given us much more than promise. After all, the times are, a confirmed optimist would say, inevitably promising. If so, so be it. Of all the things to be in the way of temperament, perhaps the best would be to lead the sanguine life. It might be easier to work on the instinctive and choleric level of an active predatory organism; yet on the whole the tone of the active predatory organism is an unpleasant one. Some there be amongst us who would prefer the everyday life of the phlegmatic person busied only with indifferent concerns. Few of us would actually prefer a life of felt passivity.

APPLICABILITY OF THE FINDINGS OF THE NEUROPSYCHIATRIC EXAMINATIONS IN THE ARMY TO CIVIL PROBLEMS *

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THE mobilization furnished this country its first detailed information concerning the individual health of young men and the frequency and importance of various chronic diseases and conditions which disable. It was the first national health survey. The facts of pathological significance were obtained by the rejection of recruits and the discharge of men recently enlisted who were reported by medical officers as unfit for military service. The total of unfitness approximated 16 per cent of all candidates. The unfitness was a static fact, not a production of war.

The neuropsychiatric examinations disclosed an astonishingly large number of men suffering from nervous and mental disease or defect. As compared with other groups of disease, the nervous and mental group stood fourth in order of frequency, rejection for these causes being exceeded only by rejections classified under diseases affecting (a) eye, ear, nose, and throat, (b) bones and joints, (c) heart and blood vessels.

The nervous and mental group had a sanitary and economic importance its relative standing by no means indicated. Many of the purely physical disqualifications, while making soldiering impossible, were in fact minor and did not imply an inferiority on the part of the individual which would prevent him from competing, on equal terms, in many civil occupations. In contrast to that, rejection for nervous causes not only implied an economic inferiority, but also—and this

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especially in the most numerous class, the feebleminded—that the individuals were actual hindrances to civilization and were prone to increase rapidly their kind.

Up to May 1, 1919, the army returned to the civil community approximately 72,000 of these cases. The army returned what the civil community offered it—nervously handicapped men. Although the army statistics refer only to men and to a limited age group, the figures can be used as the basis of an estimate as to what the number would be if children, women, and men outside the military age were counted. Such a total would be large enough to leave no room for doubt that nervous and mental diseases, which are after all a barometer of the mental stability of the people, constitute important problems in public health and, as it will be the purpose of this paper to show, in preventive medicine. Yet as national problems they receive scant attention. In public-health programs they are almost entirely disregarded, and there are only two or three medical schools which make a pretense of adequate instruction in neurology and psychiatry. We build institutions and lock up in them to excess of capacity those who cannot live in society with safety to themselves or to others, but we do not study causes nor do we strive to control or prevent what is susceptible of substantial control and prevention.

The patients who passed through the hands of the neuropsychiatric officers of the army in the United States, and who were fully classified up to May 1, 1919, were all unwounded, and may be considered under eight headings, viz.:

1. Psychoses, or mental diseases	7,910	or 11 per cent
2. Epilepsy	6,388	or 9 per cent
3. Organic nervous diseases	6,916	or 10 per cent
4. Glandular disorders affecting growth	4,805	or 7 per cent
5. Neuroses, or functional nervous diseases	11,443	or 17 per cent
6. Inebriety (alcohol and drugs)	3,878	or 6 per cent
7. Mental defect	21,858	or 31 per cent
8. Constitutional psychopathic state	6,196	or 9 per cent

As far as the eight different classes of nervous defects are concerned, a detailed discussion of all of them would be out of place here. The first four are medical rather than sociological problems, and can be dismissed with brief notice. The war

showed the economic and humanitarian importance of proper care of the insane. Grave symptoms, under the methods established throughout the military hospitals, would disappear and the patient go on to speedy recovery; whereas the same patients, had they been put into prisons as they used to be, would have met a very different fate. In fact, it was definitely shown that physical restraint is rarely necessary in the treatment of insanity.

The last four classes—namely, the neuroses, inebriety, mental defect, and psychopathic states—are also, like the preceding, intricate medical problems, but they are much more than that. They are social conditions—everyday social conditions. Every employer of labor, every parent, every one concerned with public policies, is constantly encountering, to his dismay, individuals from these four classes, without recognizing them or knowing what to do with or for them.

Such persons are not only ineffective themselves, but they make others ineffective. It is in them that mental contagion, which leads up to hysterical mass movements, spreads with the greatest rapidity, and in their minds sedition finds an easier root than reason. They are sick persons, whose symptoms appear as abnormal behavior. Their prevalence concerns the health of the country, but still more it concerns the country's morale. No real reconstruction for them can take place until the problem they present is understood by the non-medical community. Doctors must ascertain the facts in the first place, but it is from men who are not doctors that must come the provision for research into the causes of these disorders, on the one hand, and for the legislation necessary to make approved remedies effective, on the other.

The war unearthed a new social problem when it revealed throughout the United States a dissemination of functional nervous disease—i. e., nervous manifestations with sound organs—beyond all expectation. The lurid stories of "shell shock," or neurosis, abroad, while they emphasized the significance of lowered morale in soldiers, obscured the real issue and diverted attention for a time from the seriousness of the question as a peace problem here at home. Our present statistics, which represent a cross section of American youth untried by war, showed 11,000 cases and more—one-sixth of

the total of nervous and mental rejections, more than the insane and inebriates put together. There were no previous data concerning them. Fairly accurate estimates as to the frequency of insanity and mental defect have been possible for several years, but the neuropsychiatric examinations of the army furnish the first statistics in relation to functional nervous disease. In the mechanism of neurosis is to be found a condition of mind which induces a person to avoid or get out of a disagreeable personal situation because he is "sick." The "sickness" gets worse as the situation becomes more imminent or acute, and improves as soon as it recedes. It is mainly a subconscious affair, and in this respect different from malingering. While some patients of this class must be considered to be trying as hard as they can to put up with or to overcome the obstacles in their path, in most there are faults which require correction before they can really help themselves. These faults are in general physical make-up, but especially are the results of faulty training and education. The individuals are thus more or less overpowered and prevented, without help and restraining, from behaving differently. The symptoms are legion, deceive parents, associates, and (too often) medical men; as a result of all which the neurosis takes a firmer hold on its victim.

In the ordinary course of life the patients are those who haunt clinics with vague complaints, who throw up their jobs, who are always more or less idle or ailing. Rich and poor are affected alike. In social movements they seldom are leaders, but go to swell the inert mass of humanity which is easily inflamed, for a time, by untried doctrines.

In the army, neuroses prevailed among those lacking in resistance to physical strain, or deficient in those traits of character which may be embraced by the term virility. In the first class were those who failed to recover normally from physical traumata, sudden or long drawn out, and, in the second, those in whom no cause was apparent, but who did not seem able to keep up a strong heart in the face of trying or even disagreeable circumstances. A strong coloring of unwillingness to serve in the army was spread in both classes.

The cases presented certain differences, depending upon whether they made themselves known in this country or in

France. The home patients, many of them, brought their symptoms with them to camp, or else presented them soon after enlistment. They either had not been able to put up with peace conditions, or else the idea of war, as it grew nearer, was too much for them.

These patients gave little or no service and were separated from the service, 71 per cent of them, in less than three months. They ate up hospital beds with voracity. An analysis made of one hundred hysterics at Plattsburg revealed that sixty-one of them had spent more than two-thirds of their total service in the military hospitals.

But those who came under the observation of the special neuropsychiatric officers by no means represent the totals that strained medical personnel and equipment. In army hospitals many of these patients passed unrecognized by the physicians in charge and were held under some other diagnosis, of which gastro-intestinal disorder was the favorite. Such a state of affairs is not confined to the military hospitals. It is probable that 10 per cent of patients in medical wards of hospitals throughout the country to-day are those whose chief trouble is functional nervous disease and who receive little or no benefit from the treatment accorded them. The hospitals provide beds to no purpose and the patients lose more than their time.

Thus the mobilization, in uncovering so much functional nervous disease, has brought us face to face with a social problem far greater than any one could have suspected. We are almost in a position to state that these personality disorders produce a greater degree of ineffectiveness than insanity, and are to be counted among the most important of the pathological causes of unproductiveness.

They have become a pressing subject of reconstruction, not only for ex-soldiers, but for the steady numbers which succeeding years produce.

The remedies depend on all means which provide for the treatment of large numbers, for the classification of types, and especially upon all forces which tend to raise morale and idealism. In civil life, the therapeutic efforts undertaken by medical men have been confined to the individual, and so have not been of much use to the country at large. Non-medical

agencies, such as boys' clubs, Boy and Girl Scouts, settlement agencies, playgrounds, etc., promise most in the line of prevention. These stabilize ideals and standards at a period of life when all habits are formed. The more that these agencies are extended, the more effectually the individualism of neurosis is combated and the fewer cases of this class will be found in our hospitals. The essentially personal preoccupation of the neurotic would be replaced by the idea of coöperation, of working together to an end, of patriotism.

The more community activities of this kind are extended, the sooner we may look for the day when the present victims of neurosis will be of more use to themselves and to the country than they were in this war. The establishment of a universal military or other government service would aid this social extension and would of itself create an idea of solidarity that would assist in the development of character in the pre-military-age period, and later would carry on the ideal of working for something outside of one's self which is the greatest foe of neurosis.

The mobilization demonstrated a degree of feebleminded-ness in this country which takes most thinking men by surprise. There were more mental defectives rejected at draft boards and camps, or discharged soon after enlistment, than any other neurological or psychopathic patients. They constituted 29 per cent of all neuropsychiatric rejections among whites, 48 per cent among blacks. More were found among drafted men than among those who were inducted, and more in certain states than in others. The total number exceeded 24,000. Throughout the country the incidence of feeblemindedness among drafted men was 6 per 1,000, which is probably below the incident rate in the total population. In certain sections large numbers of them were foreign born. For example, 31 per cent of the rejected feebleminded recruits from New York had come to this country as immigrants, although our laws are specific in excluding this class.

In spite of the large number rejected, it is probable that more feebleminded were accepted for service than any other class of recruits inapt by reason of nervous and mental diseases. This is partly due to the fact that minor grades of defect are difficult to identify in hasty examination, and also

because no one knew two years ago just what in the way of military service might be expected of a mental defective. Consequently, large numbers of them accumulated in the troops, causing no little embarrassment. From the whole experience we are able to draw important lessons, both military and sociological, concerning the management of mental defectives as a national problem.

Specialists knew that feebleminded young men, perhaps one-third of them, could be trained into workers of at least 50 per cent normal efficiency and that 73 per cent of even institution inmates were capable of useful labor. It, therefore, seemed possible at the outset that feebleminded recruits might be trained in the army. Therein lay the error. For it requires time and patience to train a mental defective to become a useful element of an organized machine, and the training must be begun early and be carried out under highly specialized conditions. To fill such requirements in our establishment was entirely out of the question, and indeed it is doubtful if any army is organized in a way to make such a system of training practical. Even if practical, it seems hardly worth while, for the class of labor at which mental defectives are particularly efficient is agricultural, a means of supply for an army, but one better operated under other governmental departments.

There is little doubt that in future the interests of the country will best be subserved if mental defectives are not accepted for military service. But both state and federal governments should take up the problem immediately. It is for them to realize that the feebleminded, useless, costly, and dangerous if left to themselves, as for the most part they are now, can be useful as agents in food and other supply under proper management, segregated on farms. There seems a good future for even the low-grade feebleminded boy as a farm colonist, after some institutional training.

While not insisting upon a universal predisposition on the part of those who fall the victims of the diseases and conditions already mentioned, it is certain that most of them have less than normal nervous resistance to the exactions of existence, and in this sense must be called psychopathic.

In addition to those already in the grip of nervous or

mental disease or defect is a separate group, of which the members, at the time of any one or more examinations, present no symptoms definite enough to justify their being classed with any disease type. Some are superficially brilliant, enthusiastic, laying some claim to brief leadership, but unbalanced, changeable, and eventually disloyal to any organization. Suggestible, they easily become the tools of designing propagandists in spreading seditious doctrines, or in the commission of acts in defiance of law and order. Others are characterized by abnormal personality traits, such as suspicion, self-consciousness, obsessions, lack of control, and their social histories reveal disorders in the sphere of behavior. They have records of having repeatedly got into undesirable situations without the capacity of getting out again unassisted. They do not profit by experience—on the contrary, they fall into the same pits over and over again. They are recidivists, whether the undesirable situation is criminal or not. They are individualists and unsuitable for work in coöperation with others. They would have been in constant trouble in the army, and it was a good thing for them and for the military establishment that 6,196 of them were rejected by the neuropsychiatric examiner.

They and all other psychopathic personalities lead naturally to the subject of delinquency, as the psychopathic make-up is so largely represented among offenders. It would be a conservative estimate which placed the proportion of the mentally diseased or defective, without counting the purely psychopathic personalities, among the inmates of our civil penal institutions as low as one-third. The mentally deficient alone almost reach that proportion, as is shown by the 1918 report of a special committee of the New York Commission of Prisons appointed to investigate the matter of mental disease and delinquency. Based on the mental examinations of inmates at several different institutions were found:

	Feebleminded
In state prisons	25.0 per cent
In reformatories	26.5 per cent
In penitentiaries and workhouses	33.5 per cent

Thus psychiatry and criminology have become closely

linked. An example of how closely is furnished by the records of delinquency in our army. Based on previous experiences, the estimates made by competent authorities at the beginning of the war put the number of delinquents to be expected from an army of 3,000,000 men at 50,000. The actual figures up to the spring of 1919 were 4,000 confined in the Leavenworth Disciplinary Barracks and 10,000 in guardhouses, including the A. E. F. There are only a few factors which can have an important bearing on this discrepancy, and which are novel as compared to our previous experience. It is possible that by the draft a more representative and on the whole higher grade of men were inducted into the army than was represented by the regular army previously. Another cause is prohibition for the camps and cantonments. But these two causes fail to explain the difference between what was predicted and what actually happened. While general figures on this point are not at present available, there can be no doubt that the presence of neuropsychiatric examiners materially assisted in the reduction of delinquency. They did this by assuring the exclusion of potential delinquents from the army and through their coöperation with judge advocates, both in the camps and in the field.

It would seem, then, that the great lesson of the war, as far as neurology and psychiatry is concerned, is a final demonstration that our communities contain definite fixed quotas of crippling and multiplying diseases for the control of which no adequate provision exists, and that the sufferers from these conditions are handicapped in their relations to society and that many of them burden and injure it. We have now a unique opportunity to change our attitude and improve our policies in these matters.

Efforts should be made to secure sound regulations and laws and the enforcement of them regarding nervous and mental undesirables as soldiers or as foreign-born citizens; standardization of state care of all kinds; community agencies to improve the health and morale of neurotics; common sense in the management of drug addiction and the federal control of the manufacture and sale of habit-forming drugs; state control of the feebleminded, and a careful adjustment between the parole system, colony, and institutional care; the exten-

sion of the principles of the psychiatric clinic at courts and in correctional and penal institutions, and the legal denial of full liberty of the social defective.

The basis of the whole sociological program is the recognition and classification of subnormal personalities and a supervision in accordance with the varying needs of the different classes. If there is any one point at which intensive psychiatric and psychological study should begin, it is not difficult to be certain where that point is. It is in childhood and early adolescence. In these periods there is a humanitarian and economic importance in the identification of members of the psychopathic family that is lost in adult age. It is school children, not prison inmates, whom we may hope to reclaim. It is at the time of habit formation that a neuropsychiatric program can promise constructive results. Then, tendencies to insanity, to the neuroses, to delinquency can be recognized, and it is then that they offer a reasonable chance of correction. Well-formed habits made at that time are worth more to the individual of subnormal mentality than intelligence. The development of psychopathic and criminal traits are frequently the creation of improper environment. Too many children are left unsupervised in criminal homes, in drunken homes, in divided homes. Twelve per cent of the boys and more than 50 per cent of the girls placed on probation in the state of New York have been brought to the court in the first place on account of improper guardianship. Many normal children become deviates under this, and the subnormal have little chance of character survival.

The principle of classifying subnormal children on the basis of intelligence and personality should be widely extended. It should be followed by assignment to special classes for such as can be benefited by such classes (90 per cent) and institutional care for others. At the end of the school period, the subnormal should not be turned loose on the community, as they are now, but placed under a parole system directed by a suitable commission, and, in the event of their failure, committed for a time to an organized institution, where many can receive the training denied them at home. With the proper development of the special classes and the probation system, the need of institutional care will become progressively less,

as it must, because no legislatures will provide institutional care for all. There are, for example, 41,000 feebleminded in the state of New York outside institutions. The educational departments of our states and municipalities are therefore the most promising agencies in the control of the menace of nervous and mental disease and criminology.

If all the various measures, or modifications of them, which have been outlined were adopted, one would be safe in predicting an immediate drop in our insane rate, criminal rate, and an increase in our productiveness.

Why have they not been adopted? One significant answer to this question will be found in the indifference on the part of the medical profession to nervous and mental disease. What medical school to-day, what general hospital, gives any but the most meager and grudging representations to neurology and psychiatry? Our medical faculties have done so little to encourage interest and knowledge in these subjects that some of the most important social features connected with them have been brought to public interest by laymen. Indeed, we are so behindhand in these matters that there is a question if American neurology and psychiatry will ever attain the position they should have unless there is established a special foundation for research and teaching, to do for the menace of nervous and mental disease what is being done as a matter of course for physical diseases. It really seems that a care-free foundation were the condition for the firmer, broader, more scientific grasp of the subjects which bring us into closer relation with human nature than any others. Trained men are wanted everywhere, a wider dissemination of knowledge is wanted. Men trained in mental medicine are needed at the state hospitals, in the Public Health Service, in the courts and the schools, to carry on the principles of the few psychiatric clinics thus far established. Where are they to come from? What medical school is in a position to train them?

A great field of preventive medicine is before us, asking for action. Perhaps in the past the proofs of the need have not been plain enough. That explanation no longer holds good. The public-health importance of nervous and mental diseases no longer permits of evasion.

THE EXPERIENCES OF THE CHILD: HOW THEY AFFECT CHARACTER AND BEHAVIOR*

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IN his studies on infancy, Professor Watson presents[1] us with a series of observations made under the accurately controlled conditions of the laboratory. Such a presentation may lack the charm of that of the poet, for whom

> Our birth is but a sleep and a forgetting;
> The soul that rises with us, our life's star,
> Hath had elsewhere its setting
> And cometh from afar:
> Not in entire forgetfulness,
> And not in utter nakedness,
> But trailing clouds of glory do we come
> From God, Who is our home;
> Heaven lies around us in our infancy!

but it has the advantage of dealing with the real infant, observations on whom can be controlled and confirmed. The poet appeals to our emotional side, to our longing for continuity between this brief earthly existence and the unknown, which reaches before and after. While we are grateful for the beauty of the poet's conception, it would seem unwise to make it the basis of action; if we are going to give children the help to which they are entitled, it is well to know the real child, not merely the child of the poet's world.

At the present moment, the real child is engaging the attention of many workers; of those whose special tasks have to do with the child, of others whose tasks seem farther afield. Those who deal with the broader aspects of human endeavor, with history, ethics, sociology, education, criminology, are

* Read as part of a symposium on the Mental Hygiene of Childhood before the Third Convention of Societies for Mental Hygiene, the Waldorf-Astoria, New York City, February 5, 1920.

1 *The Psychology of Infancy.* By John B. Watson, Ph.D., Johns Hopkins University. The first paper in the symposium.

beginning to pay much attention to the individual; the economist begins to study the man who makes the goods; the criminologist is interested in the individual delinquent; the teacher wonders if after all a child may not be something more than a mere school unit, a passive receptacle; it is even dawning on the physician that, behind the collection of organs and chemical equations, there is the patient himself waiting for some attention and study.

From whatever angle we come to the study of the individual—whether on account of a strike, a murder, or a stomach ache—that study inevitably leads one to a review of the past experiences of the individual, for we are what our past has made us, we react to the present in a manner largely determined by our past experiences. The past is not dead and buried; it is part of the living fabric of our present character.

Dr. Watson has outlined some of the threads on the framework of our constitution, and it is on this warp that we weave our life, with the experiences and influences that destiny puts at our disposal. At every period, the living fabric is conditioned by these factors; the constitutional patterns of reaction, which Dr. Watson is studying, we have to accept, but those interested in mental hygiene are striving to see that there are no needless flaws in what the individual weaves, that faulty structures and discordant colors are not inevitably woven in at an early stage, rendering correction at a later stage tedious, painful, and sometimes impossible.

It is easy to give examples of how faulty threads get woven into the permanent pattern of the individual's life. An elderly patient, of exceptionally well-balanced personality, is even now afraid of the dark, unable to go into a dark room; this little flaw is the living residual of what happened half a century ago, when a thoughtless nurse teased a scared child with imaginary dangers.

A child of tender years, brought up in a very strict atmosphere, had an experience difficult to digest; for the next ten years all social relationships were poisoned by the living influence of this memory and its emotional radiations.

A solicitious father found that his five-year-old daughter had been initiated into sexual matters by a boy; he punished

her in a rather drastic way. When the patient had a mental breakdown in the thirties, she talked freely of this incident; it seemed all through girlhood to separate her from others— "It was a drag on my mind."

Most people realize that such dramatic experiences may leave a permanent sensitiveness, but few realize the importance of early influences in relation to the commonplace events of everyday life. For instance, parents are apt to think that so long as the physiological demands of nutrition and sleep are satisfied, the psychological factors involved in food and sleep habits can be ignored. As the child passes through the various phases of his development, he has to meet a series of tasks: he has to learn to adapt himself in an orderly manner to the problems of nutrition, of sleep, of cleanliness; he has to learn to accept certain social restrictions and conventions, to allow for the rights of others, to modify native self-assertiveness, to distinguish between make-believe and reality, to respond to standards of truth and honesty and decency, to put forth effort in the face of his tasks, to develop independence of judgment and action and feeling. The way in which simple problems of childhood are handled molds the child's habits, and the ability to meet the later tests of life will be modified by his training in relation to the early tests. The child, capricious in diet, insistent on his own sleep conditions, obstinate in refusal of regular toilet habits, gaining his own ends by the display of unpleasant tantrums, will have difficulty in adult life in adapting himself to the demands of a real world, which is not prone to bow before tantrums, which exacts inexorably the price for neglect of simple hygienic habits; at an age when these problems should have been turned over to habit, leaving the man free for his real tasks, we find him tinkering with his bowels, studying his diet, groaning over his unsatisfactory sleep.

A few examples may be given to show how simple problems of childhood are apt to be handled.

A girl of five refused to go to sleep unless her mother was with her; she would not sleep if she knew that her mother intended to go out. If the mother sat down to read the paper, the child would sit up in bed and keep awake to make sure that the mother did not go out. As the mother could neither

go out, read, nor continue her work under the decree of this dictator, she solved the problem by going to bed about the same time as the child.

In many cases the mother of a nervous child tells how she had to rock the child in infancy for hours, had to sit beside the child, had to accept many conditions imposed by the child. But in the majority of these cases she had to do it because she could not stand the displeasure and protests of the child and preferred to gain peace at the moment rather than to establish the child's sleeping habits on a good hygienic basis at the price of a transitory period of friction.

The five-year-old dictator mentioned above objected to nearly all food except sweets; if crossed, she pulled her hair and stamped her foot. She teased her little brother and objected to her mother's paying attention to other children.

A boy of nine was still sleeping with his mother because he was afraid to sleep elsewhere; when he was transferred to his sister's house, he at first refused to go to sleep if his mother were not in the house. Any sickness of the mother caused him great solicitude; he was afraid that she would die, and said that in that case he would die the same minute. He dominated his mother; at his bath he would create an uproar if she did not arrange his clothes in just the order in which they were to be put on. The mother would not accept the suggestions which the physician made for a better régime; she said that it made the boy sick if she insisted upon his doing something that he did not want. One may add in regard to this boy that for breakfast his milk had to be flavored with coffee, that he had tantrums when crossed, and that his mother had taken very seriously complaints of pains in his legs, which disappeared after a single visit to the clinic.

As the child may dictate the sleeping conditions, so he may refuse to adapt himself to the objective conditions of a suitable diet.

A boy of eight would refuse to eat if he did not get what he wanted; he insisted on tea and coffee. This régime was merely a continuation of the conditions of his infancy; he had been nursed every time he cried, he had been breast fed until three years of age. It is not sufficiently realized that mental hygiene begin when the child is put to the mother's breast.

Not infrequently children have the knack of vomiting when urged to accept a suitable diet; this is rather disconcerting to the parent, who is liable to surrender, but a parent conscious of the important issues involved will soon eliminate this mode of reaction.

The vomiting may be a defense against other annoyances than that of healthy diet. Thus a boy of seven for some time had suffered from episodes of vomiting. The first attack occurred when he was punished for teasing his sister. Since then, he had vomited whenever punished at home or at school. As to his diet, he refused to touch meat, milk, or eggs. The important principle to keep in mind in relation to such problems is that, if a child finds that through somatic complaints or idiosyncrasies he can dominate the environment and avoid the effort of adapting himself to the reasonable demands of the environment, an association is formed which, under the stress of adult life, may again be utilized and, instead of facing his responsibilities, the individual may develop obscure invalidism.

In a case such as the following, one has to face a more complicated development. A girl of eleven had attacks of vomiting preceded by a feeling of pressure on her chest; she said, "Sometimes when I am helping mother, I get real dizzy and have to leave my work and fall down somewhere." These symptoms did not come from any serious disorder of any system or group of organs. They were due to the influence of the environment on a specially susceptible individual. The girl delighted in imagining all kinds of dramatic scenes—e. g., that a "bum" had snatched her purse, she was screaming, there was a scuffle. No wonder that in her dreams she reveled in scenes of horror—apparently terrible, really fascinating. She loved to play at being an actress; she would jump on the table in her nightgown, sing and dance and fall in a swoon. With this delight in imagining herself a person of prestige and interest, and in living out her dreams, it is no wonder that she had been much impressed by a paralyzed girl next door, who frequently vomited, and that she had borrowed some of her symptoms for the drama of her own life. One may add that this girl liked to imagine that she was her sister and that a beau came to take her out; her official

statement, however, was, "I don't bother the boys. I guess I'm a boy hater."

In this case the clinical symptoms, adopted for dramatic purpose by a girl of impressionable nature, were fostered by an atmosphere of interest and solicitude, which always guaranteed an audience.

In the above cases very simple examples have been given of the fact that even in the simple activities of the child imporant issues are involved.

When one passes from such simple situations and considers the developing complexity of the interests and the activities of the child, and the multiplicity of influences that come into play, the material becomes too rich for detailed discussion in a brief paper. One can choose for special mention the preponderant influence of the parents on the evolution of the child's personality and the far-reaching effect of the early emotional values given to the manifestations of the sex instinct.

The influence of the parents on the child is profound; the attitude of the child to father and mother frequently gives the keynote to the adult character. The early devotion of the child to the parent may determine the attitude of the adult to one of the main problems of adult life—the problem of mating.

The primacy of the image of the mother and its penetration of all later objects of devotion are well illustrated in the words of dedication addressed to the nurse of his childhood by Robert Louis Stevenson:

> My second mother, my first wife,
> The angel of my infant life.

This influence, so penetrating and persistent, may be balanced by the natural evolution of those interests of the child which go outside of the family, but in some cases it is unduly dominant and hampers the evolution of the personality. Under this influence the adult may refuse to marry, or the marriage may sadly miscarry owing to lack of emancipation from the early bonds of attachment to the parent.

The uneasiness which some parents show at the approach of suitors for their children is often the continuation of a degree of fostering care which from the beginning has hampered the

free and independent development of the child. It is difficult for the parent to realize that the child is an individual with its own life to live out, its own tests to face, entitled to an independent view of existence, its own standards, its own tastes and distastes.

The parent with expansive ego tries to extend his life past the generation to which he is entitled, and lives again in the person of the child and, not content to watch and foster the new and independent life, insists that it shall be the vehicle of his own prejudices and strivings. Thus one father, jealously warding off all suitors from his daughter, merely continued an influence which had shown itself much earlier, when he had mothered the child and supervised every detail of her life, to the detriment of her personality. Another father of similar type frankly admitted that it would break his heart when his daughter married.

Too often parents have less care for the independent and healthy development of the personality of the child than for the child's conforming to certain of their standards; and this parent often belongs to the solicitous type, apparently most anxious to do everything for the sole good of the child.

It is thus that much of the repression that characterizes the influences surrounding the child arises; the parent, with his or her own personal difficulties, sensitiveness, repressions, likes and dislikes, unable or unwilling to see the origin of these, insists on the child's eliminating those reactions which touch the sensitive spots of the parent. Thus the child, naïvely exposing itself, talking of tabooed subjects, referring to the toilet, asking where babies come from, using improper words, finds the placid atmosphere unexpectedly electric. The gods express displeasure; lucky for the child if there are no thunderbolts.

What is the result on the child? Certain natural interests and activities acquire great emotional significance; they are set aside as different from other interests and activities; a mystery attaches to them; thoughts about them cause vague unrest and turmoil.

Such is the result of the reactions of nurse or parent or teacher, of the environment of the child, a result which is neither desirable nor necessary. It is not desirable because it

is apt to remove from frank discussion topics which are going to be difficult enough in any case for the child to solve. It is not desirable because false emotional values are thus given to the child and later it may be difficult, if not impossible, to transform them into truer values.

Surely it is time to eliminate the mystery attached to taboo; of course the child, as he develops, has to outgrow the more primitive and naïve reactions, has to subordinate them to the more mature and socially important reactions. The child can, however, be encouraged to outgrow primitive reactions without giving to them false values; he can learn frankly how more mature values supersede the less mature, but he can do this while still realizing that his native promptings and questionings are the real stuff out of which his life is to be made, and that they are all fit to be subjects of honest scrutiny and of trustworthy information.

When these principles are more generally recognized, the problem of the sex instruction of children will be discussed in a wider setting, and will not be limited to a somewhat narrow discussion of where, when, and by whom a certain body of information should be given to the child. More emphasis will be laid on the possibility of the education of the child and of the parent going on side by side, and parents, realizing that their own progressive development is one of the most valuable assets for the development of the character of their children, may thereby find the secret of perpetual youth.

PROGRAM FOR MENTAL HYGIENE IN THE PUBLIC SCHOOLS*

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IT has long been recognized that all children need hygienic surroundings in order to build up healthy bodies. It is just dawning on the world that the healthy body and scholastic instruction are not the only conditions needed to develop a normal, healthy mind. Mentally hygienic conditions are equally essential. The home should be, and the school is, the place where these can be best established and controlled.

In order that children may be surrounded by mentally hygienic conditions, it is necessary to know what they are and how to apply them to the individual child. The facts and principles of mental hygiene must be taught and practiced in the schools. To this end an outline of the mechanism by which it can be taught and applied was drawn up with reference to the needs in one state.

In Pennsylvania the school laws have for some years provided for the special education and training of the blind, deaf, and mentally deficient, as well as of normal children. In July, 1919, an amendment to the school code was passed which requires that "each child—between the ages of eight and sixteen years—who is gravely retarded in his or her school work, or who, because of apparent exceptional physical or mental condition, is not being properly educated and trained," shall be examined and a report made to the proper authorities as to whether the child is a fit subject for special education and training; that special classes in the public schools or special public schools shall be maintained for those who are fit subjects; and that the state shall pay half the expense incurred for instruction in such special classes and schools.

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This law is broad enough to cover not only the blind, deaf, and mentally deficient, but also children with all types of mental or physical handicaps.

Under the state department of health there is already a system of medical inspection by which the physical handicaps can be detected and reported, but facilities for making the necessary mental examinations, and for applying their results to the education and training of the mentally handicapped, have yet to be planned and inaugurated.

At a state conference on education held in November, 1919, a session was devoted to a program for mental hygiene in the public schools. At that meeting, with the idea in view that it is easier to criticize and find fault with a plan, and to build on its fragments, than to construct a new one, the following program was drawn up to be submitted to the state department of public instruction, which, with the state department of health, has the task of putting the law into effect. This program is intended to be merely a suggestion, a form to criticize, to amend, and to improve. It is not regarded as final or complete. It must be supplemented later by an outline of a course in mental hygiene for teachers in the normal schools, and by courses or subjects in mental hygiene to be taught to pupils in each grade of the public schools.

This outline may be helpful in other states that have a similar problem to solve.

Mental hygiene in general is regarded as being concerned with the best mental development and habits of all human beings, not only those that have poor development and habits, but those that have good ones, in order that they shall remain good. Hence mental hygiene in the schools has to do with every one in the schools—teachers as well as children.

The machinery for inculcating good methods and habits and obviating bad ones must therefore be based upon, and devised to meet, the mental hygiene needs—what we may call the ortho-psychic needs—of the normal child and of the teacher, as well as of the exceptional child, including the brighter-than-average or precocious, the backward, the neurotic, and all who are otherwise in any way different from the healthy average.

1. *The Needs of the Normal Child.* The normal child needs to have its resting periods and study periods carefully arranged and distributed both in school and at home. During the study periods, the child should be free from external distractions, and the periods should not be so long as to fatigue the child or so short as to make him feel hurried or under tension, or to break up habits of concentration. He should be trained in methods of study, as well as in topics, and the training should be under good supervision.

During the rest or recess periods in school, play or games should not be too active or exciting. At home the child should have long hours for sleep, should get to bed early, and the retiring hour should not be immediately preceded by romping or other extreme excitement.

There should be adequate and suitable periods and opportunities for play, especially for group plays. Games and plays should be supervised, but not so minutely guided or directed as to take away or lessen the child's initiative, invention, or imagination.

The child should be adequately and suitably fed and the dietary should not include tea, coffee, or alcohol. Meals should be eaten leisurely and at well-regulated intervals.

The child should not be called upon to perform any but a few very simple tasks before school hours, and there should not be an excess of work demanded of him after them.

The methods of teaching should not be a mere cramming of the child's mind with facts, but rather such as to train him to use his mind in handling facts. So far as possible, they should be such as to arouse and maintain his spontaneous interest, in order to develop habits of concentration and industry.

The subject matters taught should be adapted to the child's developmental age; otherwise he may become discouraged and fall behind, when his real ability should entitle him to keep up with his class. They should be adapted to his individual capabilities and to his present and his future needs.

The subject matter should include the teaching of sex hygiene, either at home or in school, in order to prevent many of the complexes which later might lead to psychoneuroses. Mental hygiene should be taught as a part of general hygiene.

And effort should be made to teach the child to associate the right sentiments with art, scholarship, honor, love, duty, etc., in order that he may make the best sublimations and substitutions in later life.

Disciplinary measures should be administered in such a way as to develop the child's sense of personal dignity or *amour propre,* rather than to wound it and hold him up to ridicule or to greater discouragement. They should develop his self-knowledge and his self-control. Punishments and reprimands should never be administered in temper by parent or teacher.

At the beginning of school attendance and regularly thereafter, there should be thorough medical examinations.

There should be also, at the beginning of school attendance and periodically thereafter, thorough psychological examinations to determine the child's development and special abilities or disabilities. Such examinations serve to establish forms of development and can be used for purposes of pedagogical classification.

2. *The Needs of the Teacher.* Teachers are human and have their personal needs like all the rest of mankind. They have cares, anxieties, responsibilities outside the school. More and more of the functions of the parent are thrown upon the teacher. Since example is better than precept, it is incumbent on the teacher to be an example to the child in all ways, including those into which mental hygiene principles enter.

Hence, to do the most effective work, the teacher needs an adequate salary, in order to prevent anxiety and the need of outside work. If she is constantly anxious about her living conditions or fatigued from overwork, she cannot teach well nor can she use good judgment or self-control in the use of disciplinary measures. She needs to be able to have comfortable and hygienic living conditions.

Classes should be limited in size in order to allow sufficient individual attention to the pupils.

In the regular classes, the teacher should be relieved from the necessity and anxiety of handling problem children who take up an undue amount of time, attention, energy.

The teacher needs instruction and training in the principles of mental hygiene for both adults and children.

A sympathetic atmosphere in which to work is important. There should be good relations between the teacher and principals, superintendent of schools, members of school boards, fellow teachers, and parents.

3. *The Needs of the Exceptional Child.* There are many types of exceptional children. Besides those with various grades of idiocy, imbecility, or lesser types of feebleminded-ness and the "normal dull," on the one side, there are the superaverage, precocious, or brilliant children on the other. Children may be rather evenly developed or very unevenly, as, for instance, those who have an excellent memory, but poor judgment, or good powers of concentration, but poor grasp. There are those handicapped by physical illnesses, and perhaps conflicts or complexes based on them. There are others who are handicapped by unhelpful or positively harmful home or other environmental surroundings, which have led to experiences or complexes that affect the child's moods, habits, or behavior. These and others make up the neurotic, nervous, shy, morbid, imaginative, fearful, petulant, irritable, insubordinate, peculiar, and, in general, problem children. They should have all the good mental hygiene conditions needed by the normal average and in addition they especially need the periodic psychometric examinations, to help determine their present make-up and intellectual status, their special intellectual aptitudes, disabilities, lacks, special needs, and to note their rate of progress or other change.

They also need especially the initial and periodic physical examinations—that is, the medical and anthropometric ones —for the purpose of determining possible causes of the exceptional condition and of defining the special medical and physical needs.

There should be investigations of the home and of other environmental conditions, in order to determine possible causes of the child's exceptional condition and the aids and hindrances to its betterment. This investigation would include inquiry into family traits and hereditary influences.

The exceptional children need to be segregated in school into small groups, under specially qualified teachers, in rooms, schools, or institutions that are especially adapted to their needs.

At home and in other out-of-school environments, the exceptional child needs special guidance as to its own activities. This guidance should be under the direction of specialists in the field in which the special disabilities or exceptional conditions lie, and it should be in accordance with the findings of the mental and physical examinations and of the environmental investigations. Guidance should include that of parents and other persons with whom the child comes in contact, in order to bring about helpful relationships between the child and its environment.

The Program

The aim, then, is to introduce into the whole school system, but especially the grade schools, such knowledge of children and their ortho-psychic needs, such attitudes toward them and their development, such methods and subjects of education—including both teaching and learning—and such training and discipline as will help each individual child to develop the best mental powers and abilities of which he is capable, and the best attitudes towards himself, his associates, and his present and future environments and activities. This means child study, not only on a large scale, but intensively of the individual, and the application of the findings to each individual child. The application is best accomplished by taking out from the regular classes all who are exceptional in any way or degree, and placing them under observation in rooms or environments where their special needs can be studied and wisely catered to.

A program, then, should provide facilities (1) for the examination and testing of all children, to discover which ones are exceptional or have exceptional needs; (2) for determining in each child what those exceptional needs are; and (3) for giving to each the appropriate guidance, opportunities, and training.

Two suggestions are offered. One is a fairly complete scheme, not likely to be inaugurated in full and at once, but to be aimed at. It may be called "The Ideal Program." The other is a plan which can be started almost at once, and developed into the more complete one in the course of time. It may be called "The Immediately Practicable Program."

1. *The Ideal Program.* All prospective teachers in normal schools and colleges should receive instruction in the physical and mental hygienic needs of normal and exceptional children and of adults. Courses for this purpose should be planned.

All teachers should have practice teaching and observation in special schools or special classes, as well as in normal classes.

In the large centers of population, such as Philadelphia, Pittsburg, Scranton, Wilkes-Barre, etc., there should be a Central Special School, with laboratories, clinic rooms, and special class rooms, each fitted with every modern equipment for their needs. This school should be within easy access of all such medical specialists as may need to be consulted. It should have a staff consisting of psychologist, psychiatrist, psychiatric social worker, school nurse, visiting teacher, and highly trained special teachers, all of whom should be familiar with mental as well as physical hygiene. There should be a sufficient number of assistants of various types, such as clerks, stenographers, etc. This school, constituting a Bureau of Child Research, or, better, of Educational Child Study and Adjustment, should be a center of investigation into the mental, physical, and educational needs of exceptional children—including the superaverage—a training school for special teachers, and a model special school. Its facilities should be available to all children, whether they are in school or not.

By means of such a central school, which might have boarding facilities as an adjunct, it should be possible to take up the intensive study of special problems, as of the truant child, or of the shy or the hysterical or the stuttering child, or of the brilliant or precocious child, etc., much as special medical problems are studied intensively in the Rockefeller Institute for Medical Research.

There, also, studies could be made, not only of these exceptional conditions, but of the normal processes of learning at different ages, and of the best methods of teaching the various subjects of study to normal children.

There should be subsidiary district special schools, accessible enough to the central school to be able to benefit by the clinics, and to serve as experience schools for teachers.

In the remoter districts, there should be special classes with

especially trained teachers who have had courses in physical and mental hygiene, educational psychology, and social psychiatry.

In rural districts and in small towns and cities, there should be in each a community mental clinic with psychiatrist, psychologist, social psychiatric worker, and visiting teacher. This clinic should have a sufficient number of rooms, sufficient equipment, and a sufficiently large clerical force to make and keep adequate records. Such clinics should be numerous enough throughout the state to be accessible to each school, not only for periodic examinations, but for continuous oversight and guidance of such children as need them.

In each school building or school district which has one hundred or more pupils, there should be provided a special class or ungraded room, with full equipment and a specially trained teacher. In such districts as have a union high school building, such a special room, with its equipment and trained teacher, might be provided there instead of one in each grade-school building.

In the state department of public instruction, there could be established a Bureau of Educational Child Study and Adjustment, its staff to consist of a school hygienist, a psychiatrist, a psychologist, a physical-culturist, a psychiatric social worker—or a visiting teacher who has had a thorough course in social psychiatry—and such other consulting specialists as may be desired.

This bureau would have general supervision and direction of the mental and physical hygiene work in the central and other special schools, and in the special classes and special mental clinics throughout the state. It would also supervise the research and statistical work connected with all special classes conducted by these schools and clinics.

2. *The Immediately Practicable Program.* As indicated above, it is unlikely that such a complete system can be inaugurated at once. But the need exists now and is urgent. Hence the following immediately practicable program is suggested, part of which can be at once organized. The rest can be set in motion when the contents of courses in mental hygiene and special class work have been arranged, and the

coöperation of psychologists, psychiatrists, and social workers can be secured.

There should be in each normal school a course in mental hygiene as well as in physical hygiene, a course in social psychiatry, and a course in psychometric tests and preclinical investigations. These three courses might well be an expansion of the course in psychology. There should also be a course in the conducting of special classes.

To the physical hygiene that is now taught in the public schools there might be added a few simple mental hygiene precepts. Where the Modern Health Crusade has been inaugurated by the Society for the Prevention of Tuberculosis, a chore, such as, "I have done cheerfully to-day one thing that I did not want to do," might be added.

Through social-service workers, visiting teachers, or school teachers, the parents of little children should be taught how to instruct the children in sex hygiene, or this should be taught in the schools.

The psychology departments of the colleges and universities throughout the state should be invited to coöperate in making preclinical tests and school surveys, and in supplying trained psychologists for clinical purposes who shall aid in detecting precocity, feeblemindedness, neurotic and other harmful tendencies, etc. They could also guide the special education of the exceptional children.

Full use can be made of all the community and other mental clinics that are now established, and the local school authorities can be urged to aid and coöperate in the establishment of the others.

Traveling clinics can be established, with psychologist, psychiatrist, and psychiatric social worker—the latter to act as secretary and recorder—to go to rural districts and those not reached by local clinics.

Teachers can be urged to refer to the clinic all exceptional children, those above the average as well as those below, the nervous, the shy, the sulker, the truant, the insubordinate—those in any way troublesome or difficult or different from the average happy, normal child.

There should be at least one psychiatric social worker and one visiting teacher for each 2,000 pupils.

A register should be kept of all feebleminded and backward children. They should be followed up closely until they are out of school, and then they should be helped in their occupational placement.

It is to be hoped that agencies will be created to guide and follow up all children who need special oversight after the completion of school age. By means of the register and the workers above mentioned, such agencies should be notified of all children who need their service.

Appendix

It seems desirable to define the functions of certain of the personnel mentioned in the program. This will clarify their relations to each other and to the whole.

The duties of the psychologist in the clinic are (a) to make or supervise mental tests; (b) to interpret the results of the tests in terms of (1) general age level or developmental status, (2) of special abilities and deficiencies, and (3) of special individual intellectual or educational needs; and (c) to advise as to special methods and subjects of instruction in individual cases. In the bureau his duties are (a) to make investigations or direct them, and (b) to make recommendations as to further investigations or applications of the findings, etc.

The duties of the psychiatrist are (a) to determine the causes of the backwardness, defect, nervousness, or other exceptional conditions in the individual child; (b) to advise measures to correct or better these conditions or to obviate them or their causes; (c) to direct the carrying out of these measures so far as they are medical and social and not educational—i. e., concerned with the courses of study of the child; and (d) to aid in investigations.

The duties of the psychiatric social worker are (a) to investigate the home and other environmental conditions of the exceptional child; (b) to try, under the direction of the psychiatrist, to correct harmful and to establish helpful conditions in the home and other environments having detrimental influences; (c) to keep constantly in touch during school years with the child and its home; (d) to inform other social agencies of the needs of the child after school years in order

that continuous oversight and guidance may be given so long as needed throughout the individual's life; and (e) to act as recorder in mental clinics, when called upon to do so.

The duties of the visiting teacher are (a) to establish coöperative relations between home and school; (b) to help the child in home study through suitable assistance to the child and through developing right attitudes in the parents; and (c) to help parents in their relations to the child and to the school.

SOME ADAPTIVE DIFFICULTIES FOUND IN SCHOOL CHILDREN*

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IN the winter of 1916 and 1917 the Joint Committee on Education of Chicago invited a discussion, in the interests of their public schools, by representatives from the fields of biology, psychology, psychopathology, and sociology. The contributions of these sciences were presented respectively by Herbert S. Jennings, John B. Watson, and Adolf Meyer of the Johns Hopkins University, and by William I. Thomas of the University of Chicago.[1]

The trend of these suggestions, derived independently from experience and research, lies in the direction of emphasis on the study of the individual child and his needs, rather than on the reference of the individual to a group. Biology states: "We must, then, see in our flock of children a set of diverse organisms—each endowed by nature with his own combinations of fancies; each with something that no one else possesses."[2] Psychology elaborates the theme still further: "We would not attempt to prescribe just what the child's curriculum should be, but we affirm with a good deal of confidence that his individuality and tendencies should determine in large measure what we should teach him."[3] Psychology, from its wealth of experience in tracing back to child life the beginning of many an adult breakdown, can be even more concrete in its affirmations, devoting its share in the discussion to "Mental and Moral Health in a Constructive School

* Read at a meeting of the Federation for Child Study, New York City, February 28, 1920.

1 These papers have since been published by the Macmillan Company under the title: *Suggestions of Modern Science Concerning Education.*

2 Jennings, Herbert S. Op. cit., p. 18.

3 Watson, John B. Op. cit., p. 80.

Program."[1] In this lecture Dr. Adolf Meyer defines the school's great opportunity and responsibility as that of helping "the child and parents find the best level and direction of ambition adapted to the individual endowment."[2] Or, as he recasts the statement: "The highest aim of education will always lie in the proper encouragement and training of certain emotional assets, the interests, leanings and curiosities, ambitions, likes and dislikes, as well as of purely intellectual assets or knowledge."[3] As a practical outline of procedure towards this end, Dr. Meyer suggests that "a school physician with training in psychopathology attend regular conferences at which the management of the problematic pupils is brought up and discussed. The instances calling for special study might then be taken up under the direction of the physician, perhaps by a teacher . . . detailed for part of her time to make a study of the home situation and of all those facts which the physician needs if he is to make a thorough study of the individual. . . . A most useful life record can readily be made of the fundamental assets and traits and needs of each child and of fairly specific home problems, supplemented by the record of the assets brought out by a thorough personal examination by a competent physician."[4]

Under the inspiration of this vision it was the writer's privilege, in January, 1918, to begin in a small way the practical application of these ideas to a definite school unit. The school chosen for the experience was Public School 76, which lies in the heart of the Locust Point district of Baltimore, an area surveyed by Campbell[5] for the subnormal child, in 1914. By virtue of its geographical position, the Locust Point district is more or less of an isolated community, united by common industrial interests, which enjoyed a boom during the late war. The Point is devoid of colored inhabitants. The population is to a large extent of foreign extraction, and not uncommonly uses the German, Polish, and Hungarian languages in its homes. Since the closing of the thirty saloons and

1 Meyer, Adolf. Op. cit., pp. 103-156.
2 Meyer, Adolf. Op. cit., p. 136.
3 Meyer, Adolf. Op. cit., p. 148.
4 Meyer, Adolf. Op. cit., pp. 134-136.
5 Campbell, C. Macfie. *The Subnormal Child: A Study of the Children in a Baltimore School District.* MENTAL HYGIENE, Vol. I. pp. 96-147. January, 1917.

the dance halls attendant upon many of them, Latrobe Park and several moving-picture shows furnish desultory recreative opportunities. Aside from one or two parochial schools struggling against the inevitable survival of the fittest, Public School 76 contains the majority of the children in this district, enrolling about 800 in its attendance. Housed in a dilapidated building on the edges of a barren waste, and overflowing to the extent of several grades into an abandoned dwelling house across the street,[1] School 76 gradually has come to be not only a sort of community center for the Point and a beacon among the public schools of the city, but its achievements are not unknown to many people in other parts of the country. It is not the school "bank," the classes for backward, defective, and tuberculous children, the penny lunches, the coöperative scheme with the Children's Playground Association and the Public Park Board, or even the full-blooded Parents-Teachers' Association that are so worthy of comment as it is the fact that this school is peculiarly identified with the community from which it springs. Besides the arbitrary need of the three R's, it recognizes the children's need of adequate opportunities for play, for self-expression through vocational training, music, school plays, etc., for healthy amusement from clean, stimulating picture films; it recognizes also the parents' need of encouragement and guidance in the out-of-school problems of home environment and growth, as well as their need of understanding and helpful discussion of domestic anxieties and financial struggles. Such is the school-community setting in which the following work was taken up with Miss Persis K. Miller, the principal of School 76, to whose creative genius and common-sense understanding of human beings the writer is also indebted.

By way of further preface it might be stated that the fifteen school months during which this study was made were interrupted by no less than three enforced school holidays of from two to eight weeks each, due to the influenza epidemic, the

[1] With the burning of the school building in January, 1919, the school authorities lost no time in getting under way a building that will be the last word in school architecture. This structure will serve not only as a schoolhouse, but will act as a social, recreative, and educational center for the entire community.

freezing and bursting of pipes, and finally the burning of the main building itself last January (1919), with a consequent scattering of the children for temporary accommodation in other schools. These circumstances, together with the fact that only two days a week could be devoted to this work, may serve to comfort those who mourn that only 46 children were seen during the above period.

Without benefit of theory in psychology or pedagogy, and unconcerned with matters of statistical output and production, the writer devoted the first few weeks of the venture to a leisurely acquaintance with her new environment. To this end there was no room-to-room canvass for difficulties of adaptation or any other concerted activity, unless it were the repeated denial that she was there only in the interests of the mentally defective with some variation of intelligence standardization, which is generally supposed to be the purpose of any psychopathologist within a school area. On the contrary, the writer strove to drive home the idea that she had not come to teach, nor yet to offer a new program of reform, but merely to learn whether or not one accustomed to studying sources of failure in individual human beings could be of any help to those who must be baffled and perplexed by these very difficulties of adaptation in their childhood setting. And what better way to answer this query and swing into the tide of school life than by drifting into class rooms, enjoying their wealth of activities and reactions, and listening to the stories of teachers who bear the burden and heat of the day?

Before long the writer's question box in the principal's office contained more requests for suggestions in regard to specific children than it was possible to compass. They came, and have continued to come, from the kindergarten to the eighth grade, with a breadth of distribution exceeded only by the diversity of the individual complaints. Of the 46 children who came under observation, 35 were reported as having difficulty in keeping up with their grade in one or more subjects. In each of these cases where there was a suggestion of retardation, the Binet-Simon test was supplied. As a result, 16 of the above-mentioned 35 were found to have a mental retardation of from three to six years. The academic troubles of the remaining 19 were associated with, if not the disguised ex-

pression of, such faulty psychobiological reactions as shyness, laziness, inattention, vicious tendencies, sensitiveness to criticism, daydreaming, hypochrondriacal fears with resulting irregular attendance. The 11 remaining from the total 46 were referred for the more overt adaptive difficulties of temper tantrums, sullenness, crying spells, twitching, indifference, excitability, poor coördination with the hands, quarrelsomeness, etc.

So familiar are the majority of these reactions in the world of everyday that only the student hurrying along some avenue of special inquiry gives pause, perchance, to consider these facts as the vague result of still vaguer causes. Faulty nutrition, inadequate exercise, the strain of defective light and ventilation, a poorly balanced school curriculum mustering under the banner of science, figure from time to time in drives of public health and educational controversy as abstract sponsors of these unhealthy manifestations of child life. But can one study such twists of behavior and mental attitudes in terms of abstract physiology, pedagogy, or "child psychology"? What are the concrete facts about the shyness, twitching, and inattention of John and Henry? These children are first of all individuals, with their respective psychobiological endowments and acquisitions. Each is as distinct in the habit data of his total-function as in those of his special organs. He has had his own start in birth, early development, training, and home influences, as well as in sleeping, eating, and other factors of so-called personal hygiene. To understand his trouble in concentration, his temptations, his impulsive behavior, his lack of satisfaction in work and play, one must have a life record of the individual child in the stories of parent, teacher, physician, and child himself. The excavation of these stories, according to the writer's experience, has not been difficult. With a few exceptions, parents have talked frankly and been eager to understand and learn how to readjust any matter as far as possible, even to the point of personal sacrifice.

It is impossible, within the scope of this article, to discuss all of the cases outlined on the chart, or even to do the justice of detail to those reviewed. One can but disclose a bit of the wealth of opportunity for service which lies buried in this

whole school situation, in the hope that it may stimulate further research.

M. W. (No. 4)[1] was a boy of eight in the third grade when first seen in March, 1918. He was referred for examination because his mother had written the teacher that M. was a "nervous child" and should be put in the open-air class. Aside from his being fidgety and desperately mischievous, the teacher saw no signs of "nervousness" in the child, but dared not discipline him because of his mother's note.

History: The father is a steady, thrifty worker; the mother an excellent housekeeper. There is one other child—a bright, healthy girl of ten years. The patient had a normal birth and early development. His habits of eating and sleeping were good. Out of school he was constantly active, leading the boys in play and trying by stealth to reproduce mechanical contrivances which he had seen, although his mother forbade his using tools for fear he would hurt himself. Two or three night a week he went to the movies. The patient began kindergarten at five and came up at the rate of one grade a year. He has always been an excellent scholar, but "more trouble to look after than the whole room put together." Three years previously, according to the mother, M. W. began suddenly to have "shaking spells" which "commenced in his hands and went all over his body." During these attacks, he would drop anything in his hands. The family physician said that he was "on the verge of St. Vitus dance" and should be kept as quiet as possible. His mother herself had noticed that these "spells" were apt to come on when he was irritated or crossed in any way. Both the family and school physicians reported his general physical condition as good.

Examination. March, 1910: The patient was a ruddy, talkative little boy who looked the picture of health. Knowing that the examiner was a physician, he began at once to talk of his "nervousness," in which he showed an energetic interest. When asked to reconstruct the setting of the first "shaking spell," he said it came on him one day when he had been called from play to go to the bakery. On the way back,

[1] Cases Nos. 4, 12, and 13 were discussed by the writer in a paper read at the International Conference of Women Physicians, New York City, October 9, 1919.

he got so "weak and trembly" that he dropped the bread in a mud puddle. Since then the family had not trusted him to run errands, but had sent his sister instead. (What do people think about these spells?) "Mother is scared, and the doctor says I might have St. Vitus dance." (And father?) "He tells me to cut it out." (Who makes you mind best?) "Father. I don't mind mother. She just keeps on talking and telling me what she's going to do, but I know she doesn't mean it." The patient was courteous enough to explain to the examiner, as a newcomer at the school, that the open-air class sat outdoors all winter and had "swell grub, too."

Neurological examination was negative. The heart sounds were clear and the pulse was normal in every respect.

Suggestions for Modification: The mother was seen again and the nature of her son's attacks was not only explained to her, but reinforced by a verbatim account of his opinion of her methods of control. It was urged that she drill herself into not worrying over the child, but insisting on instant and exact obedience, utterly ignoring any flapping and shaking he might display. It was also suggested that the boy be given as many concrete outlets as possible for his energy and development of initiative along constructive lines—for example, that he be given a workshop in the cellar or backyard and be allowed to work as he wished, building aëroplanes and other machinery which he wanted to construct, regardless of possible dangers from carpenter's tools.

Subsequent Notes. October, 1919: The patient is now leading the fifth grade. He and a chum have a shop in the cellar where they spend hours at a time, turning out some very fair models of the neighboring dry docks. The father says that M. understands every part of an automobile and often finds the hitch in a stalled truck which his repair shop mechanics fail to locate. A note from his mother reads, "Dear Doctor: Please ask M. is he nervous any more and who cured him?" The boy himself, in answer to the question, "How are the spells?" replies with a smile, "I don't have any more of them. I run errands now."

In contrast to the above, from the standpoint of inferior home environment and less intelligent antecedents, is the case

of J. B. (No. 13),[1] who was first seen in May, 1918, at which time he was 11 years old, and was repeating the third grade. The teacher said, "J. is slow in his class, and is always going to the dispensary for some trouble that the doctors say they cannot find."

History: The father is alcoholic and shiftless. The mother is a weak, unstable individual. There are four children younger than J. The patient had a normal birth, but up to two years of age had to be carried on a pillow because of a "wasting disease," said to be due to prolonged breast feeding. He was twenty-two months before a tooth appeared. Since the age of five, he has made his home with his maternal grandmother, who lives across the street. This arrangement was the result partly of crowded home conditions and partly of the father's antagonism to the boy, which was accentuated during the former's drunken sprees. As to living habits, the patient retired any time from 10 to 12 p. m., sleeping in a bed with two grown uncles. Coffee and fried potatoes were the only foodstuffs he would eat. He began kindergarten at five, spent two years in the first grade, one year in the second grade, and at the time of examination was repeating the third grade. In class he seemed slow in grasping what was taught, but showed no other characteristics, except that he was constantly asking to be sent to the dispensary. He had been gone over repeatedly by the doctors there, with negative results. The mother stated that for the last two years he had come home from school with "nervous crying spells," complaining of headache, dizziness, nausea, and shifting pains in the abdomen.

Examination. May, 1918: The patient was normal according to the Binet-Simon tests. He was a thin, pale, angular boy, who twisted his fingers and clothing, and bit his nails. There were occasional jerkings of the head, facial twitchings, and sniffings. He was without fever or cardio-vascular disturbance. During the examination, he answered questions relevantly and promptly, but showed little interest in the way of voluntary conversation until his complaints were inquired into.

[1] See footnote page 336.

1. Headaches: "I got 'em when I was in the first grade. They are like my mother's and get worse when I'm worked up over something. When I think of people dying, I get nervouslike and cry. I think my nose is going to close up." He had heard it said that adenoids should be cut out or they grow and "shut off your breath." His nose and throat examination has been persistently negative.

2. Pains in the Stomach: This symptom developed about two years ago, when he complained of pains in his right and left abdomen. Questioning brought out the fact that the distress was coincident with hearing his mother talk about a girl who had "a cancer cut out of her stomach because she wore her clothes too tight." The patient worried for fear he would die from something like that. He discarded his belt and hitched his trousers on with a safety pin.

3. Pains around the Heart: "I get pains around my heart, and sometimes I feel to see if it is going. Grandmother tells me to rub it like she does when she gets 'em, and makes me go to bed with hot ginger tea. Mother has 'em, too. I can't run no more. I get out of wind. I used to run on the Public Athletic League track, but I gave it up on account of my heart."

Suggestions for Modification: The patient's mother agreed to see that the boy had a bed to himself and that he went to it reasonably early. She also promised to modify his diet as far as possible. As a hygienic lift, it was suggested that for the remainder of the school year the patient go into the open-air class, where he could have supervised nourishment at least once a day. The boy himself was assured that there was nothing wrong with his body. His mother was urged to send him to school regardless of his complaints. He was placed in the open-air class, but after the first day objected so bitterly to the food—soup, milk, bread—that his mother cooked him the fried potatoes and coffee for which he called. She excused herself with, "He vomits if he doesn't like anything he eats." The patient, when interviewed, seemed ashamed of his backsliding and compromised by returning to school lunch and belted trousers.

Subsequent Notes. November, 1919: In appearance the patient has good color and looks bright and alert. His flesh

is firm and he has gained in weight. He is now in the fourth grade, and is perfectly regular in attendance. There seem to be no complaints. The patient eats heartily and has consulted a physician but once in the past year and a half, and then for "a touch of flu." He has taken up gymnasium, basketball, running track, and swimming.

Discussion: One sees these two children, as yet only within their first decade, adjusting themselves to the circumstances of life in a decidedly inferior manner. The one, keen, alert, energetic, stumbles by accident on a trick which, with the help of his own constructive imagination, the maternal concern, and therapeutic perplexity, soon elaborates itself into a habit reaction that enables the patient to escape drudgery, discipline, and all the other inhabitants of Pandora's box in a way quite compatible with his self-respect. The other, timid, suggestible, fearful of disease, gradually absorbs the complaints of his environment to the practical exclusion of all the healthy interests and ambitions of an average boy of his age. Had their teeth or tonsils or eyes or ears or lungs been weighed in the balance of medical examination and found wanting, would these children have been allowed to continue without reconstructive attention on the theory that they would outgrow these unhealthy biological manifestations? And yet many a "neurasthenic" invalid, crowding the benches of our dispensaries or draped over our rest-cure homes, could tell a childhood story of traits in common with J. B. if his physician only took the trouble to round up these data. The caprices of the libido in many an hysterical syndrome might be less occult and illusive if one were in possession of such early habit facts as M. W. developed.

The next case represents a not uncommon group of children of whom the teacher says: "They do fairly well in their work, but I feel they could do a great deal better if they were not so shy and sensitive. They seem afraid to get up and recite, and cry if I correct them in any way. At recess they either hang around the schoolroom or, if they go out into the yard, they always play with children much younger because those of their own age tease them." The mother tells the same story. It is a story of children who hesitate to go to the store on an errand, or to go into public places, who disappear

when somebody comes to call at the house, or fail to speak up and answer questions as the other children do.

G. O. (No. 12)[1] was a boy of ten who was repeating the third grade when we became acquainted in April, 1918. His teacher complained, "G. is so hard to get at. I feel as though there is a lot in him if I could only reach it."

History: Since his father's death three years before, the mother had supported herself and her son by washing car windows from 7 a. m. to 6 p. m. When not in school, the boy stayed at home by himself, getting his own meals and reading such books as *The Swiss Family Robinson.* He seldom played with other boys, for the reason that they picked on him because he was so "old-fashioned." He had no dog or ball or roller skates. His chief pastime was daydreaming and building imaginations around stories of adventure he had read. The patient entered kindergarten at six, was a year in the first and second grades respectively, and had apparently lodged at the third. In school he was a source of annoyance because he would stare into space for ten or fifteen minutes right in the midst of class exercises, and then return to earth with a confusion and embarrassment made worse by the ridicule attendant upon his having lost the place in the reading lesson. His mother reported that G. had never been like other boys. His feelings were always hurt, so that after correcting him for some little thing, she not infrequently found him half an hour later crying by himself in some other part of the house. "The other day," she continued, "the teacher corrected him for something for which he was not to blame, and was too busy to listen to his explanation. G. came home that night and was very quiet all the evening, when suddenly he said, 'Mama! I'm not going to that school any more. I don't think they want me there!' "

Examination: The patient was a pale, sober-faced child who talked slowly and seemed to deliberate over his answers. During the examination, he was not distracted by children passing to and fro in the hall, which is usually a disturbing factor in these interviews. He said he liked to be alone because other people made him uncomfortable, and that he

[1] See footnote page 336.

liked best to sit still and dream. (Do you dream more at home or at school?) "More at home because I have to work in school." (How does this dreaming work on you?) "Well, I might be sitting down, and mother or teacher would be talking to me, and I wouldn't hear until they kind of woke me up." (What starts it?) "I don't know. Sometimes I just do it. Or I'll be looking at something, or maybe catch some word I hear, and then all sorts of things come into my mind." (Such as?) "War and Indians, and being a soldier when I grow up, and a lot of queer things." (Could you show how it works?) "I don't know. It comes best when I'm doing nothing at all." At this point the examiner was interrupted for a few minutes. During this time the patient sat quietly, with every appearance of listening to the conversation. When the interrupter was gone, the patient was asked what this conversation was about. "I don't know. I was thinking of something else. I was wondering how the top of this school would look on top of those houses over there, and all funny things like that."

Suggestions for Modification: The mechanism of this behavior was explained not only to the mother and teacher, but to the child himself. It was advised that his hours at school and at home be filled with as many concrete activities as possible, such as playing games, acting as school messenger, etc. The patient was transferred to the fourth-grade work and the teacher asked to see to it that he was kept up to snap, particularly in his oral and board work, where he could easily be lost in the general clamor for self-expression .

Subsequent Notes. December, 1919: The patient completed the fourth grade and is now doing good work in the fifth. He is ambitious and full of initiative in and out of school. His daydreams have practically disappeared, being replaced by such interests as the Boy Scouts, gymnasium class, and roller skating. By a fairy turn of fortune, the family resources were revived by the mother's marrying a steady, wage-earning widower with a boy about the patient's age. In this way G. was not only provided with the wherewithal to take steps in the direction of more activities, but was also furnished with a congenial little companion to keep him on the job.

Discussion: This story is a description of facts quite within the range of our normal experiences, so much so, indeed, that many readers will wonder why these facts are the object of concern and study. Are not shyness, sensitiveness to criticism, and "wool gathering" *per se* always with us as benign invaders of childhood? To be sure they are, and yet their combination in children like G. O. is associated with a faulty adaptation obvious enough to constitute a problem for teachers and parents as well. In the instance cited, one sees the sensitiveness and desire to be alone, which were noted by the mother as the patient's earliest and most fundamental traits, developing under bad environment into habit reactions at ten years of age that were already making him lag behind in adjustment to the situations of life. He was repeating the third grade; he was a bad "mixer;" he habitually dodged the concrete, aggressive issues of work and play by deliberately withdrawing into a dream world of his imaginations, unexpressed by any form of activity. To the psychopathologist—alas, too familiar with the limited adaptability associated with such facts of behavior—there is a startling similarity between the constitutional make-up of such children and that of the schizophrenic. An attempt to alter these shut-in trends of growth by forcing the child in the opposite direction without first teaching him to understand the condition into which he has developed is as bad as to ignore the whole manifestation because our professional forebears have done so in the past.

Turning briefly to another case like No. 4, in which the psychobiological twist itself constituted the school problem, B. H. (No. 9) was a boy of thirteen in the seventh grade when he was referred to the writer in February, 1918, for "temper tantrums."

History: The father is a junk collector, taciturn and unsocial; the mother is a quiet little woman, ambitious and friendly. Besides the patient, there are two other children, who are bright, docile, and steady. The family live in a poor locality and evidently struggle to keep afloat. The patient was a bed-wetter until nine years, and afraid of the dark. He has gone rapidly through school, easily leading his class except when he had a tantrum or "sulky spell" and then "loaf-

ing'' for several days. His tantrums began in the third grade. Since then they have appeared more frequently, at times with no obvious provocation, and again when the patient has been ''crossed'' in some trivial way. He has shown no patience with detail, but a desire to quit if he cannot do a thing at once. In his outbursts he either remained mute for hours at a time or else beat his head against the floor, cursing and yelling so that the class was disorganized. Among the boys he was noted as a fighter with his tongue, but a coward when it came to blows. At home the mother described him as beyond her reach. The father assumed an irresponsible attitude towards the boy except to beat him when their ways parted. The patient's own story, as expressed during several interviews, throws the best light on his difficulties.

Examination. February, 1918: B. H. was a clean, robust-looking boy who always wore a sulky, disgruntled expression. There were no spontaneous remarks. When speaking of his failures, he showed frankness and a certain amount of insight. (What do you think is at the bottom of these temper spells?) ''I haven't any patience to try things that are hard. If I can't get a thing right off, I don't want to touch it again.'' (What are your ambitions?) ''I care about standing first just to beat the others, but I'm not going any further in school.'' (Why not?) ''Because I'd find something I couldn't do.'' (What do you do with your spare time?) ''I read Rover Books.'' (Any games?) ''I like baseball and can play a pretty good game, but I can't get along with the fellows. I did belong to the Public Athletic League, but I got out because last year we had a game and the captain said I was 'out,' so I wouldn't play any more.'' (How about the Boy Scouts?) ''What's the use? I'd just get into fights with the boys and quit.'' (What do you do all summer?) ''I just stick around and read. Sometimes I play marbles with the boys in the street, because if I get mad, I can just go off and leave them.'' (What plans have you after leaving school?) ''I'll get a job at the dry docks at twelve dollars a week.'' (Suppose the boss finds fault with you because you don't work fast enough?) ''I'll quit and get a job at sand-papering at ten dollars a week.'' (And suppose your back aches, and the dust makes you cough, and the boss ''bawls you out''

because you haven't done as much as he thinks you should?) "I'll quit that, too." (What about two jobs in a week?) "I don't want to talk about this thing any more. I'll get along some way. I can always buy junk like father. If a man fusses with him, he just goes on and leaves him."

Suggestions for Modification: The patient refused to discuss matters further. Several boys in the school who were captains of various teams were interviewed as to the possibility of athletics acting as a substitutive outlet for the energy and emotion which the patient was putting into his temper trantrums. These boys reported that B. did not play "fair," that he cheated if he could " get away with it," and, when caught, made such a fuss that they could not have him on the team.

Subsequent Notes. November, 1919: The patient was fourteen years old in January, 1919, and left school at once. Since leaving, he has been spasmodically interested in collecting junk with his father. Between these spurts of activity, he loafs in sullen rage over the last straw which has happened to fall across the path of things as he would like to have them.

Discussion: One is struck by the fact that this husky, well-developed lad, with a bright mind and good living habits, should find nothing in life to arouse his interest or enthusiasm, and that, in spite of a surprisingly clear understanding of the exact hitch in his troubled adjustment, he remains passive towards any attempt to modify the situation. He knows well that his characteristics of behavior doom him to an economic and social status far below that to which his intellectual assets entitle him. To discuss the matter from the standpoint of an epileptic equivalent, or of laziness or natural perversity, is interesting, but quite beside the fact that here is a child who has very satisfactorily discharged the obligations of the school curriculum and yet is launched upon adult life wholly unprepared to meet its problems. Not only is he unprepared so far as stemming the current is concerned, but his very peculiarities expose him to the danger of falling into that whirlpool of chronic agitators who project their conflicts of irritability and vague dissatisfaction upon the laboring masses. Would an earlier study of this boy have revealed any facts of home management, of environment, of school

training, etc., that played a rôle in the origin and growth of his unhappy traits?

And now a word as to those 16 children who showed a retarded mental development. Much has been written on the responsibility of the school towards this large group of individuals who ought to have some kind of training and yet are incapable of assimilating the regular work. Public opinion is becoming more and more awake to the necessity of weeding them out from general classes, both in justice to the children themselves and to their unretarded fellows whose ascent they block. With one or two exceptions, there is little unanimity of opinion as what should be done with them when they have been separated. Certainly they cannot be trained *en masse*, as one might think after hearing some enthusiastic reformers discuss the question of "mental defectives." Some of these children could absorb quite a bit of school work if they had more individual attention from the teacher. The ungraded class solves this problem to some extent, especially if it is in the hands of the right kind of a teacher. In the case of children who are able to take up only handwork, the need for individual attention is even greater. For example No. 44 and No. 43 are Polish boys of fourteen who have a mental age of seven years according to the Binet-Simon test. The former is sluggish, irritable, incapable of sustained effort at handwork for more than half an hour. The latter is a constructive hustler, good-natured, gentle in bearing, sensitive, thrifty, and so quietly unselfish as to seem almost pathological among his so-called normal competitors in life's struggle. He earns eleven dollars a week, working from 6 p. m. to 1 a. m. and an hour at noon in a lunch room on the Point. The presents of candy and oranges from "the boss" he brings home to his little brother, "because he never gets none other ways. We save the money for our people in the Old Country." Already J. S. (No. 43) has one hundred and seventy-five dollars in bank. He has acquired some little reputation as a surgeon to bicycles and other pieces of machinery. And yet this boy spends all his time during school hours in caning chairs. What if these school hours were spent on work which could be correlated with some activity which the child might take up after leaving school, so that the handwork, like the ordi-

nary school program, would serve as a stepping-stone between school and the life that follows? A plan similar to this is about to be tried in connection with the Department of Labor. According to its outline, a certain number of backward boys are to spend an equal time in school and in factory or store, the periods for each alternating week by week. Teacher and factory boss are to get together on the needs of these boys. At the same time the school is to have supervision of them until they are sixteen years of age. In this way it is hoped that much of the friction may be averted between employer and this type of employee, whose limited adaptability and temperamental idiosyncracies drive him from one job to another until he finally stays in the drifting-labor class.

In conclusion let it be stated again that the studies outlined in this report were not undertaken for the purpose of obtaining statistical data on the neurotic child, nor yet for the purpose of adding to what has already been described in regard to the psychotic constitution. That some of the material presented can readily be correlated with these syndromes is as natural as that other case material falls into the group of mentally retarded children who are the subject of most school surveys in the interests of mental hygiene. On the contrary, this work was taken up solely with a view to discovering some of the common adaptive difficulties of childhood which every teacher has to face, and to finding whether or not these difficulties can be understood and modified for the mutual benefit of child and teacher. Rough and unfinished product though they are, one feels that these case reports are the earnest of an affirmative answer. The children cited in illustration are not indigenous to the locality in which they were observed. They are counterparts of boys and girls in all social strata. Their fathers and mothers, the writer believes, are not unique in their responsiveness or in their desire to meet honest inquiry halfway. Like other parents, they are prone to spoil their children, to excuse their faults and magnify their virtues. And yet many a mother has found time to snatch an hour from her morning's work to go to the school and talk over the problems of one of her brood of seven. The suggested modification of some pet theory of discipline which has worked well in the "raising" of the other six is as hard a

truth for her to face as is other criticism to her better educated and more socially correct sister who sends her children to private schools.

And how does one draw out mother and teacher and child, and what does one do with their stories? There is no mysterious technique about it all, any more than there is ever a cut-and-dried recipe for talking matters over with people. Fortunately these particular parents and teachers never trouble themselves about asking, "What do you call it?" but rather, "What can be done about it?" Together we sift *all* the facts of each case, rendering unto diet the things that are diet's, and to living arrangements the things that belong to them, at the same time not forgetting that retardation, fatigue, lapses of conduct, and various other types of sagging may also have their source in dissatisfaction in work or play, embarrassment, overstimulation, lack of opportunity for self-expression, poor habits of work, or discrepancies between assets and ambitions, between tasks assigned and individual capacities. And the greatest thing one can bring to the study of such problems is a mind so unprejudiced by special lines of thought that one is not forever trying to formulate a panacea for the mass, but is willing to apply time, patience, and common-sense understanding to the child here and there who finds it hard to get on with the world of activity and thought.

Upon the school, for the most part, and particularly on the public school, devolves the task of helping the child to find his own usefulness and contentment in life. The school is meeting this responsibility well, not only by increasing the flexibility of its curriculum to suit individual needs, but also by thrusting its arm of kindly authority out to safeguard the health of the child, with school nurse, free dispensary, baby weighing, open-air class, and hot lunch. But while it safeguards the health of its pupils on these biological foundations, it is baffled by many an unhealthy twist of personality which constitutes as serious an individual handicap to the activities of life as infected tonsils, poor living habits, or meager educational opportunities. Where do these defects of balance come from? Are they to be traced to constitutional inheritance, to home influences, to school sources? The answer is in every instance an individual one, and can be

determined only through a careful study of all the facts of each case. The data along this line herewith submitted are so far merely suggestive. Will these tendencies toward breaking increase or diminish with the strain of years? The writer hopes to have the privilege of following this question up through the grades of school and at least out to the first job, before pausing at the threshold of the answer.

It is a pleasure to thank the superintendent of schools and the school board of Baltimore for permission to undertake these studies, which are an outgrowth of the work begun by Campbell in 1914. The writer also wishes to express her sincere appreciation of the patience and intelligent coöperation of Miss Persis K. Miller, Principal of Public School 76, and her splendid corps of teachers, without whom these facts could not have been gathered. Credit is due to Dr. Adolf Meyer above all, not only for the conception of this plan and its practical accomplishment, but also for his untiring interest and helpful suggestions.

TABLE I — CHILDREN OF SCHOOL 76 REFERRED FOR EXAMI

NOTE: In these tables, B. stands for boy, G. for girl, M. for mother, F. for father, T. for

No.	Sex	Age	Grade	Difficulty	Onset	Habit data
(1)	B.	8	2	Handwork (writing, drawing, etc.).	Kindergarten. 6 years.	Occasional bed-wetter.
(2)	G.	8	2	M. reports screaming spells at night.	Kindergarten. 6 years.	Walked and talked at 11 months. Afraid of dark; sleeps in mother's room.
(3)	G.	8	1	T. says, "Hard to get her attention." M. says, "A nervous child."	Kindergarten. 7 years.	Sleeps with mother. Bed at 11 p. m. Fussy about food. Vomits if forced to eat bread with a meal.
(4)	B.	8	3	M. says, "A nervous child." Has twitching and choking spells.	Kindergarten. 5 years.	Good living habits.
(5)	B.	11	4	Cried daily through 1st and 2nd grades. Sensitive.	1st grade. 7 years.	
(6)	G.	10	3	Cried through 1st and 2nd grades.	1st grade. 6 years.	Talks in sleep; afraid of dark; easily startled.
(7)	B.	8	2	Cried through 1st grade. Trembles so he cannot recite.	1st grade. 7 years.	
(8)	B.	6	1	Cries so he cannot recite. Corners of books nibbled.	Since entered, Sept., 1917.	We know very little about causes of this familial reaction.
(9)	B.	13	7	Temper storms.	3rd grade. 9 years.	Bed-wetter till 9 years. Afraid of dark.
(10)	B.	9	3	Slow in spelling, shy, too bashful to recite; trembles when called on in class.	1st grade. 6 years.	Bed-wetter till 9 years. Afraid of dark.

NATION BECAUSE OF SOME DEFINITE ADAPTIVE DIFFICULTY

teacher, R. for repeated, B. S. for Binet-Simon.

Association facts	Suggested modification	Subsequent notes
Lazy; spoiled at home. No interest except reading.	M. and teachers unite to subordinate reading to handwork, toward better balance of achievement.	Patient's marks in despised subjects come up from "Poor" to "Good" and "Ex." Requires constant prodding. Transferred to another school.
Jealous of younger brother and sister; craves attention. Easily excited, tense.	Patient should sleep in separate room. M. and T. to ignore "nervousness," which patient uses to have her own way.	Patient now in 3rd grade, getting on so far without friction.
M.: Vomits "if things go wrong." Excitable. Patient is only child; spoiled at home.	Better food and sleep habits. M. realizes patient copies her behavior.	No more vomiting or fussing over food. Leaving school in 2nd grade. Transferred.
M. oversolicitous; afraid to discipline.	Constructive outlet for patient's energy. Insist on obedience. Ignore nervous tricks.	Patient is leading 5th grade. No more nervous reactions.
M. timid and keeps to herself. Children all cry at home and are afraid of everything. Not allowed to play with other children. M. says, "I just have to cry at nothing. I never fuss with anybody. I just cry."		Patient has ceased to cry since 2nd grade. Is still shy in play and self-conscious.
		Patient has not cried in school since 2nd grade. Timid and afraid of things.
	Emphasis on written work.	Patient bids fair to enter upon the non-crying stage, as the others have.
Uneasy, squirming child. Bursts into tears at any personal question.		Through process of time patient has come to adjust himself to school life as his brothers have.
No ambition or interests. Cannot get on with any one. Cheats in games. Coward.	Unsuccessful attempt was made to get at root of the tantrums and find some interest to act as balancing factor.	Patient left school at 14 in the 8th grade. Is working with his father "off and on."
Great reader. Too shy to play with children. Ashamed to show spelling papers. Afraid people are laughing at him. Wants to be by himself. B. S. normal.	Encouragement and letting child follow his initiative rather than failure and forcing in opposite direction. Special study of the spelling problems.	Patient is in 4th grade. Doing better work. Goes out on the playground at recess. Gym. once a week. Still timid and unaggressive.

TABLE I — CHILDREN OF SCHOOL 76 REFERRED FOR EXAMINATION

NOTE: In these tables, B. stands for boy, G. for girl, M. for mother, F. for father, T. for

No.	Sex	Age	Grade	Difficulty	Onset	Habit data
(11)	B.	10	Ungraded class.	Habitual truant. Wets and soils himself at times.	Always has been untidy.	M. died when patient was 1 year. Neighbors gave him what care he got until stepmother came 2 years ago.

BECAUSE OF SOME DEFINITE ADAPTIVE DIFFICULTY—*Concluded*

teacher, R. for repeated, B. S. for Binet-Simon.

Associated facts	Suggested modification	Subsequent notes
B. S. normal. When truant, patient is often found wandering alone in some deserted spot. No explanation from him. No play interest or work ambitions. Parents resent inquiry into case.		T. feels she has obtained some response in improved personal appearance and more regular attendance.

TABLE II — CHILDREN WHOSE APPARENT BACKWARDNESS WAS ASSOC DIFFI

NOTE: In these tables, B. stands for boy, G., for girl, M. for mother, F. for father, T. for

No.	Sex	Age	School history	Difficulty	Onset	Habit data
(12)	B.	10	R. 3d grade.	"Is he backward?" Hard to get at. Loses place in reading. Slow in grasp.	Kindergarten. 6 years.	Bed-wetter till 9 years. Always slept with mother. Poor living arrangements.
(13)	B.	11	R. 1st and 3d grades.	Slow to grasp work. Constant dispensary visitor, complaining of headache, dizziness, etc.	1st grade. 6 years.	Bad start with "wasting" disease. Backward in walking and teething. Sleeps 3 in bed. Late hours. Eats only coffee and fried potatoes.
(14)	G.	13	R. 6th grade.	Backward?	Kindergarten. 6 years.	Poor home conditions. Always fighting with other children. Afraid to sleep alone.
(15)	G.	14	R. 7th grade. Entered 6th grade from Catholic school.	Quarrelsome; sulks when corrected.	6th grade.	Family in comfortable circumstances.
(16)	G.	13	R. 3d and 6th grades.	Backward?	3d grade. 10 years.	Two or three trashy novels a week. Movies every night.
(17)	B.	14	R. 1st and 6th grades. 7.	Dull and stupid	2d grade.	F. and M. dead. Patient lives with uncle and aunt who spoil him.
(18)	B.	10	R. 2d and 3rd grades.	Is he dull? Doesn't seem to concentrate.	Kindergarten.	Idol of M. and grandmother. Sleeps with F. and M. Rarely corrected at home.
(19)	B.	14	R. 2d and 5th grades. 6.	Never makes any trouble or does any work.	Kindergarten. 6 years.	Diet is coffee, tea, and cake. Smokes 10 Piedmont cigarettes a day. Sleeps with M., who has to put him to bed.

IATED WITH, IF NOT THE DISGUISED EXPRESSION OF, SOME ADAPTIVE CULTY

eacher, R. for repeated, B. S. for Binet-Simon.

Association facts	Suggested modification	Subsequent notes
B. S. normal. Stays alone. Does not want to play with other boys. Gets chief satisfaction in daydreams.	Emphasis on concrete issues of work and play. Teacher to keep him on the job continually.	Patient is in 6th grade. Daydreaming replaced by Boy Scouts, baseball, swimming, etc.
B. S. normal. F. alcoholic. Patient very suggestible. Copies complaint from M. and grandmother. No home training.	Better living habits. Reassurance as to bodily condition. Cultivation of other interests —athletics.	Patient is working in 5th grade. No further complaints. Runs on track; gymnasium. Looks huskier.
B. S. normal. Shy; afraid to ask teacher questions. Gets another child to do it. Scattered interests. Daydreaming. Sudden outbursts of laughing when other children are quiet.	Concrete activities such as those advised for No. 12 met by poor home coöperation and lack of organized recreation for girls in this locality.	Patient is barely making a go of the 7th grade. Adaptive habits about the same.
B. S. normal. Frank, attractive. Said she disliked her room teacher and "acted up" to get square with her. Many interests. Library card, basketball, swimming.	Change of room teacher. Try patient as school "messenger."	Patient left school to work in June, 1918. She began factory work and took a business course in night school. At present has position as typewriter and stenographer.
B. S. normal. Scattered attention. Many weak ambitions —music, drawing, dress designing. No patience with detail. Inaccurate.	There is no coöperation from home.	Patient left school at 14 and helped her mother till her marriage, November, 1919.
B. S. 12 years. Lazy; no interest in work or play. Does slovenly work. Likes to sit around and whittle. Time-server in school.	Leave school and go to work.	He has been working steadily in ship-building company.
B. S. normal. Lazy, mischievous, inattentive.	M. urged to train patient in habits of obedience and work. To make play the goal of a good school record.	Patient is doing excellent work in the 4th grade. He says, "I didn't study before. Now M. keeps me in and makes me get my lessons." T. reports, "Good scholar; interested in everything and popular in the class."
B. S. 12. Only ambition to earn money for movies and smokes. M. is a weak, shiftless woman who can't see she is spoiling patient by giving him his own way.	Leave school and be forced by necessity to stick to a job.	M. still keeps patient in school, where he is only a nuisance. M. feels he is too young to work yet.

TABLE II — CHILDREN WHOSE APPARENT BACKWARDNESS WAS ASSOC DIFFICULTY

NOTE: In these tables, B. stands for boy, G. for girl, M. for mother, F. for father, T. for

No.	Sex	Age	School history	Difficulty	Onset	Habit data
(20)	B.	10	R. 2d grade.	Backward?	1st grade.	Good living habits. Bed at 11 p. m. Bad moral conditions at home.
(21)	G.	9	R. 3d grade.	Quarrelsome; fights all the time.	Noted by M. as earliest characteristic.	Irritable, disobedient, and lazy at home. Jealous of younger sister.
(22)	G.	13	R. 1st grade in Catholic school. R. 3d grade in School 76.	Slow to learn; irregular in attendance.	Noted on admission to School 76 at 12 years.	No play time. Patient takes care of household. Often stays up till midnight.
(23)	B.	8	R. 2d grade.	Liar and thief.	Habitual traits.	Walks in sleep. Sleeps with F. and M. F. runs a vicious dive.
(24)	B.	11	R. 3d and 4th grades.	Stealing. Cannot fix attention in school.	3d grade. 9 years.	Only child. Petted and shielded by M. Has everything he wants. Good living arrangements.
(25)	B.	11	R. 1st and 3d grades. Ungraded class.	Truant, liar. Spells of rage when crossed; curses, strikes at M., T., or strangers.	Kindergarten. 5 years.	Patient has been severely beaten daily by F.
(26)	B.	14	R. 4th and 5th grades.	Stupid, truant; disciplinary problem.	1st grade. 6 years.	Patient is second of six. Always had to hustle. Began to work at 6 years out of school hours.
(27)	G.	10	R. 3d grade.	Slow in class. Trouble in reciting.	2d grade. 8 years.	Slow in walking. Stammerer. Bed-wetter till 9 years. Two episodes this year associated with dreams. Afraid of dark.

IATED WITH, IF NOT THE DISGUISED EXPRESSION OF, SOME ADAPTIVE —*Continued*

teacher, R. for repeated, B. S. for Binet-Simon.

Associated facts	Suggested modification	Subsequent notes
B. S. normal. One sister at feebleminded institution. Poor attention. Has to be prodded to keep mind on subject. No organized play.	Special class work. Develop athletic interests.	Recent case.
B. S. normal. Parents divorced. Both have leg sores. One stillborn child. Patient has notched incisors. She has no interests; will not discuss matters.	Blood Wassermann advised.	Patient moved and went to another school. Wassermann not obtained.
B. S. is 11 years. M. alcoholic and recently acquired lues out of wedlock. F. dull and stolid. Patient is bright, alert, and easily approached.	Extra stimulus in way of playground work, folk-dancing class, etc.	Following addition to family, patient came more irregularly. Stole money and coupons from T.'s desk. Patient is now in 4th grade (Nov. 1919), and so far has shown no tendencies to steal or stay out of school.
B. S. normal. M. slatternly and unreliable. F. in constant trouble with police. Patient and his brother have stolen $20 to $60 at a time from F.'s drawer.	Industrial-school training. Home influences are hopeless.	Patient transferred by parents to Catholic school.
B. S. normal. Movies five nights a week. Fond of bandit adventures on the screen. Dreams of robbing trains.	School emphasis on positive facts. Patient made special messenger for truants. Athletics.	Patient is now in 6th grade. Not popular with the boys. No further stealing reported.
B. S. normal. M. has no control of boy. Latter has been leader of a gang of "rough necks," and takes a certain pride in his "badness."	Parental School, to try what changed environment would do.	Patient's father died summer of 1919, and patient is now in Parental School.
B. S. 12 years+. Patient is undersized, affable, thrifty. Earning money only ambition. Plans work intelligently. Has clothed himself for 3 years. Good nest egg in bank.	Chance was found for patient to learn salesmanship in large department store in town under supervision of one of their efficiency teachers. Patient eager to try it, but F. moved to country.	Patient has drifted around the country, always financially above board. He has learned no business. Has had a dozen different jobs.
B. S. normal. Patient is easily excited. Movies four times a week. Frequent dreams of robbery and assault. Crying and fright spells in night. Wants to go to M.'s bed.	Modify living arrangements with coöperation of M. Play interest.	Now in 5th grade. Timid, shy.

TABLE II — CHILDREN WHOSE APPARENT BACKWARDNESS WAS ASSOC DIFFICULTY

NOTE: In these tables, B. stands for boy, G. for girl, M. for mother, F. for father, T. for

No.	Sex	Age	School history	Difficulty	Onset	Habit data
(28)	G.	13	R. 6th grade.	Poor attention, slow grasp.	5th grade. 11 years.	Headaches for last three years. Cannot go out in sun or play.
(29)	G.	15	R. 3d and 8th grades.	Inability to reason. Poor memory. "Nervous spells."	4th grade. 11 years.	Convulsions with whooping cough at four years. Apparently had *petit mal* till puberty at 11 years. Since this age patient has had major convulsions about once in three months.
(30)	B.	7	R. 1st grade (Catholic school.) 2d grade.	Cannot make him learn. No initiative.	Entered No. 76 in 2d grade.	Bed at 11 p. m. Good food. No home supervision. M. died Oct., 1918.

IATED WITH, IF NOT THE DISGUISED EXPRESSION OF, SOME ADAPTIVE —*Concluded*

teacher, R. for repeated, B. S. for Binet-Simon.

Associated facts	Suggested modification	Subsequent notes
B. S. normal. M. subject to headaches and has 10 different medicines in closet at home. Very careful of children. At odds with the neighbors. Doesn't allow family to "mix much."	Mother quarrelsome and incoöperative. No home help can be expected.	Patient left school April, 1919. Working steadily in same place.
B. S. is 12 years+. F. is Supt. of S. S. and strict. Lights out in home at 9 p. m. Patient is shy, has never played with other children. Likes housework.	Patient was put on bromides and Fowler's Solution, with directions as to diet and general hygiene. Parents advised not to push patient beyond her assets and inclinations.	Family moved to the country where patient has taken an interest in raising chickens. Seems happy and contented. Attacks about once in three months.
B. S. normal. Likes to be by himself. Shy, sober-faced child. No voluntary talk. No play interests.	Special work in class. Development of interest in play.	Went to Catholic school.

TABLE III — CHILDREN WHO WE

NOTE: In these tables, B. stands for boy, G. for girl, M. for mother, F. for father, T. for

No.	Sex	Age	School history	Habit data
(31)	B.	13	R. 1st, 2nd, 3rd and 4th grades.	Walked at 14 months, talked at 3 years; 1st tooth at 10 months. Diet cake and candy.
(32)	B.	12	R. 1st grade. R. 2nd grade twice. Defective class 2 years.	None obtained.
(33)	B.	14	R. 1st grade. R. 2nd grade twice. Ungraded class.	None obtained.
(34)	B.	11	Ungraded.	
(35)	G.	11	R. 1st grade twice.	
(36)	G.	15	R. 1st, 4th and 6th grades.	Inattentive, giggles without cause. Plays only with little children.
(37)	B.	14	Entered 4th grade from Catholic school.	
(38)	B.	11	Entered from Catholic school in 2nd grade. R. 3rd grade.	Occasional night terrors and bed-wetting.
(39)	G.	13	Began school at 6. Waterlogged every class. R. 4th grade.	Did not walk till 3 years. Impediment in speech till 8 years. Drooled in kindergarten. Afraid of dark.
(40)	B.	13	R. 1st, 2nd, and 3rd grades.	Coffee and smoking.
(41)	B.	12	Polish Catholic school, 7 to 10 years. English Catholic school, 10 to 12 years.	None elicited.
(42)	B.	10	R. 1st, 2nd and 3rd grades. Ungraded.	Wet himself at 6.
(43)	B.	14	Catholic school from 6 to 11 years. Could not do 1st grade work. Defective class.	Patient works from 6 p. m. to 1 a. m. and from 12 m. to 1 p. m., earning $10.50 a week in lunch room.
(44)	B.	14	1st grade 2 years. Defective class.	

RE RETARDED FROM 3 TO 6 YEARS

teacher, R. for repeated, B. S. for Binet-Simon.

Association facts	Suggested modification	Subsequent notes
B. S. is 10 years. Can do simple jobs. Poor planning and judgment.	Ungraded class.	Giggles without cause, scattered attention, clean in appearance.
B. S. is 9 years. M. allows child to steal. Oldest child wayward and defective. Baby, club feet and hands deformed.		Does excellent handwork. Seems incapable of learning from books. Docile, affable. Ungraded class.
B. S. is 11 years. Patient is brother of No. 32. Juvenile Court for stealing.		Left school.
B. S. is 8 years. Patient is brother of No. 32 and No. 33. Juvenile Court for stealing.		Ungraded class. Better personal appearance.
B. S. is 6 years. Patient is sister to Nos. 32, 33, 34.	Admission defective class.	Does simple household tasks. Answers are scattered.
B. S. is 12 years. M. suicide.		Keeping house for F. Left school.
B. S. is 10 years.		Left school. Lost first job. Drifting.
B. S. is 8 years. Stolid, dull; gives wild, irrelevant answers.		Indifferent to work. Not impudent. Needs constant urging to follow directions.
B. S. is 9 years. Has no sense of responsibility. Is scattered, flighty and quarrelsome.	Defective class.	Transferred to another school. Left that school. Not traced further.
B. S. is 8 years.	Defective class.	Catholic school.
B. S. is 7 years.	Defective class.	Catholic school.
B. S. is 7 years. F. is German. Antagonistic to school.		Teachable. Good personal appearance. Learning to spell, but cannot write simple note.
B. S. is 7 years. He is quiet, straightforward, thrifty, and responsible. Has $175 in bank already.	This child could be taught a mechanical trade.	Recent case.
B. S. is 7 years. Brothers feebleminded. Dull, stolid, easily irritated; cannot stick to handwork.		Slovenly appearance. No progress even in handwork.

TABLE III — CHILDREN WHO WERE RET

NOTE: In these tables, B. stands for boy, G. for girl, M. for mother, F. for father T. for

No.	Sex	Age	School history	Habit data
(45)	G	14	R. 1st, 2nd grades (3 years). R. 3rd grade. Defective class.	Poor living conditions. M. works. Children on streets.
(46)	G.	14	4 years in 1st grade. Defective.	Poor home.

ARDED FROM 3 TO 6 YEARS—*Concluded*

teacher, R. for repeated, B. S. for Binet-Simon.

Association facts	Suggested modification	Subsequent Notes
B. S. is 7 years. Discontented, sulky, stubborn, irritable.		No improvement. Leaving to work at home.
B. S. is 7 years. Family of defectives. Easy-going disposition.		Leaving to work at home.

MENTAL DISORDER IN ADOLESCENCE

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ADOLESCENCE is generally recognized as a critical period in the mental life of the individual. Not only is it a period during which disorders are very apt to develop, but it is also a time when the mental balance of probably every boy and girl is disturbed to a greater or less degree. This is shown in a variety of ways, as, for example, by a tendency to become irritable and discontented or to indulge in daydreams and romantic fancies. The changes in behavior and disposition which young people display at this time frequently make them difficult to deal with and cause a great deal of trouble and worry to those who are responsible for their care and upbringing.

Now why is the mental balance so frequently disturbed during adolescence? It is because this is a period of transition, a period during which the habits and tastes of the child are being replaced by those of the adult. Childhood is merely a preparation for adult life. During childhood, the individual develops, under the shelter of the parental wing, those qualities of mind and body which he must have before he can lead an independent existence. Adult life, on the other hand, is the productive period. When the individual enters upon this phase of his existence, he ceases to depend on others for guidance or protection. He becomes self-supporting. The training which he has received as a child he now utilizes in the performance of useful work. He also performs a procreative function, begetting children and caring for them until they, in their turn, have attained full development and are able to take their places as productive members of society.

And since the child and the adult lead such different lives, nature has given them different mental qualities. To each has been given the type of mind that fits him for the life he must lead. For example, since the child must depend upon his parents and other "grown-up folk" for guidance and support, his mind is of a type that, as a rule, impels him to

submit readily to their authority; since in games and mimic struggles he must train both body and mind for the serious activities of later life, his play instinct is very active. He also possesses an active instinct of curiosity which leads him to acquire a knowledge of the world about him, and he displays a tendency to imitate his elders that gives him a familiarity with types of reaction that in later life are likely to prove useful. Since the adult, on the other hand, must regulate his own life, he is, as a rule, more self-reliant than the child and less willing to submit to the will of others. Since he must perform a procreative function, he has active sexual and parental instincts which impel him to marry, to beget children, and to care for them. Since he must be a productive member of society, his inclinations turn less to play and the acquirement of general knowledge and more to those forms of activity which serve some practical purpose.

Adolescence is the period of transition from childhood to manhood. During this period, the boy's instincts undergo a profound change. The tastes and inclinations that belong to childhood give place to those of adult life. New desires, new interests, new trains of thought are awakened. The boy discovers that the various activities and pleasures which hitherto have made up his life no longer satisfy him. He must, therefore, alter his manner of life in order to bring it into harmony with these new tastes and desires. He must discover how he may best satisfy the new instinctive demands that have awakened within him or how he may hold them in check when to satisfy them is impossible. Not infrequently he fails to handle these emotional forces in a satisfactory way, and that is why the mental balance is so often disturbed at this time. When the boy is unable either to gratify or to regulate these newly acquired impulses and desires, a state of emotional tension is produced as the result of which he is irritable and ill-tempered, the dammed-up emotional forces finding outlet in bursts of temper. Or these forces may find outlet in various other unwholesome forms of activity. For example, he may give outlet to his sexual impulses in the practice of masturbation, and not infrequently, when he fails to find in the world about him the means of satisfying his desires, he turns for satisfaction from reality to daydreams and a world of his own

imagining. Sometimes he is impelled by these forces, which he has not yet learned to control, to forms of behavior that get him into serious difficulties, and in certain cases his thought and conduct may depart so radically from what is normal as to constitute a psychosis.

The following illustrative case will serve to show something of the mechanism by means of which the instincts that become active during adolescence may give rise to abnormal forms of thought and conduct.

The case is that of a Jewish boy who lived in the congested tenement district in the lower East Side of New York City. He lived in a small and none-too-clean apartment with his father, mother, and elder sister. None of the family was emotionally well balanced. The father was an excitable man and a victim of "nervous indigestion." He had a very violent temper and was a tyrant in the home. Conversation was always hushed when he entered the house. The mother was a timid woman, continually worrying over trifles. She suffered from a mild form of diabetes which her physician claimed was due to her "nervousness." The sister was an excitable, hot-tempered young woman who, when her brother angered her, as he did quite frequently, would scream aloud, attack him with her fists, bombard him with dishes, knives, forks, or anything else that came to hand. The boy himself had always been quite unstable. On the one hand, he was timid and easily frightened; on the other, he possessed a violent temper to which he gave free rein on the slightest provocation. This lack of control was, of course, to be expected in view of the emotionally unstable stock from which he had sprung. Moreover, the environment in which he lived was not conducive to tranquility of mind, nor was the example set by the older members of the family such as to lead him to cultivate his powers of repression and self-control. But in spite of his emotional instability, he had been able to get along fairly well, both at school and at home, during the pre-adolescent period. This, no doubt, was due largely to certain good qualities that he had which tended to offset his faults; for he was intelligent, industrious, affectionate, and conscientious.

On the approach of adolescence, however, at about the age of thirteen or fourteen, he began to show, in a very marked

degree, the increased irritability which, as I have already pointed out, young people not infrequently display at this time. This of course was to be expected. Different people react differently to the same situation or emotional strain, and the type of individual who would show the most irritability under the emotional strain of adolescence is the one who, like this boy, is by nature excitable and lacking in self-control, who has all he can do to control his temper at the best of times.

He also developed at this time a great liking for the theater; he wanted to be continually going to vaudeville and moving-picture shows. Now this craving for pleasure and amusement, which is a marked characteristic of young people generally, is another result of the stirring of new emotional forces. The boy turns to various forms of amusement in an attempt to satisfy his newly awakened desires. He turns to them as a means of emotional outlet. And of the pleasures to which he may turn none has a stronger or wider appeal than the theater. The adolescent is dissatisfied with the life he is living. He longs for something new and different. He wants excitement, adventure, romance. The theater gives him all this. It takes him away from his own unsatisfactory life into one which is thrilling and fascinating. Moreover, since he is able to identify himself to a certain extent with the actors on the stage or screen, he is able, in witnessing their portrayal of intense emotion, to give outlet and expression to his own.

About the same time, the boy began to grow disobedient and difficult to manage. Here, again, he was merely manifesting a tendency that is quite common in adolescence. It is normal for a boy, during this period, to develop a spirit of independence which impels him to draw gradually away from parental control until in course of time he attains to the condition of adult independence. This readjustment of the relation of parent to child is frequently not accomplished without a good deal of difficulty. Much depends on the boy himself. If he is lacking in judgment and self-control, his tendency to assert himself may lead him to act in a foolish and unreasonable way that will render him a very hard problem for his parents to deal with and may carry him along into courses of conduct that will give rise to serious trouble. Often, however, the fault lies largely with the parents. If, as not infre-

quently happens, the father is tyrannical and domineering, if he refuses to allow the boy the steadily increasing degree of liberty of action which is his due, he is standing in the way of the boy's normal development, and the result is likely to be a conflict between parent and child which, however it turns out, cannot but have bad results. If, on the other hand, the parent is weak and overindulgent, the boy may get completely out of hand before he is able to regulate his own life properly, and the result may be equally disastrous.

In the present case, we have all the factors that stand in the way of a satisfactory adjustment. We have, in the boy himself, an individual who is lacking in self-control and who has always shown a tendency to be carried away by his emotions and impulses. We have parents who are lacking in judgment and emotional balance. It is not surprising, therefore, that the development in this boy of the tendency to assert his independence should give rise to serious difficulties. His mother was weak and indulgent. With her he was not only defiant and disobedient, but also gave way freely to his tendency to irritability. If she told him to do anything, he not only refused to do it, but allowed himself to fly into a rage. His reaction toward his father, although equally unhealthy, was quite different. This was because his father, instead of erring on the side of overindulgence, was harsh and tyrannical. The boy did not dare to give way to outbursts of temper in his father's presence or to defy him openly. But the spirit of revolt was not quenched merely because it was so harshly held in check. On the contrary, it was probably stimulated thereby, and it impelled the boy to use the weapon that the weak and timid have always used against the strong. He resorted to deception. As a child, he had been fairly honest, but now he began to lie. If his father told him to do anything, he would say that he had already done it, or else promise to do it and then not keep his word.

About this time he became dissatisfied with going to school. He wanted to leave it and go to work. This was not due to any trouble with his teachers or fellow students. As a matter of fact, he had always gotten along very well with them. He was merely showing another of the reactions that boys commonly display during this period. There are a number of

factors lying back of the desire of the adolescent boy to leave school. In the first place, there is the stirring of new instincts and desires and the awakening of the new trains of thought which they suggest. These absorb the boy's attention and make it hard for him to concentrate his mind upon his lessons. As a result, they become difficult and distasteful to him, and he wishes to give them up. In the second place, because the life he has been leading fails to satisfy the demands of his newly awakened adult instincts, he becomes restless and discontented. He longs to make some radical change in his manner of life. For this reason, the idea of exchanging the schoolroom for the office or shop appeals strongly to him. The third factor is the spirit of independence which now develops. The boy chafes under the authority of parents and teachers and sees in leaving school and going to work a means of escaping from it. This undoubtedly was an important factor in the case we are considering. The boy himself states that one of the reasons why he wished to leave school was that he might get away from his teachers, who were strict with him. A fourth factor is the desire of the boy to earn money, so that he will have the means of indulging his taste for the theater or other forms of amusement which, as I have already pointed out, now begin to make a very strong appeal to him. Finally, there is the stirring of newly awakened adult ambition, a desire to get started on what is to be his life work. This the average boy expects to find in the world of business, not in the schoolroom. We all turn to the kind of work that is congenial or that we think will be congenial, not merely for the material rewards that we hope it will bring to us, but for the satisfaction, the emotional outlet, that we find in the work itself. This tendency holds true of the boy as well as of the man. He is impelled to leave school because he desires to find some occupation in which he will get a degree of satisfaction that his studies do not give him, in which he will find a satisfactory outlet for his emotions.

This motive probably played a particularly strong part in the case we are considering. In this boy, the inherent fondness for trading and handling money, which is such a marked characteristic of his race, was very highly developed. From childhood, he had always shown this inclination toward a

commercial pursuit. It is not surprising, therefore, that he should show, more than does the average boy, a keenness to get started on a business career. That his inclination toward business was largely due to the satisfaction he found in the work itself is shown by the way he responded when the school children were called upon to assist in the sale of war-savings stamps. They were allowed to absent themselves from their classes at this time in order to go out and sell stamps. Of course it was to be expected that a boy might take up this work merely in order to escape from the classroom and the authority of his teachers. In such a case, however, he would probably work rather half-heartedly, being satisfied if he sold merely enough stamps to justify his absence from school. But this boy threw himself into the stamp-selling campaign with tremendous energy. He worked early and late, selling more stamps than any of his fellow students. In this he was not actuated by a desire for profit, for he received no remuneration for his efforts. He was not actuated by patriotism, for he knew little about the war and cared less. In fact, his leanings, in so far as he could be said to have any, were pacifistic. He was actuated, as he himself said, merely by the fact that he found the work congenial. He liked selling things and handling money and found in this form of activity a means of emotional outlet.

Now, in selling war-savings stamps, he was reacting to the demands of his nature in a fairly healthy way. He was allowing his emotional forces to find outlet, as our emotional forces always should find outlet, in the performance of useful work. But his love for trading and handling money, combined with his antagonism to his father, presently carried him into quite a different course of action, one that was quite unhealthy and that was to give rise to very serious difficulties. While walking along the street one day in the part of the city in which he lived, he saw some boys selling various articles to a man with a pushcart. The idea struck him that he might take some things from the house, belonging to his father, and sell them to this man. From what we know of the boy, we can easily see why this idea would appeal strongly to him. In the first place, it gave him an opportunity to gratify his taste for trading and handling money. In the second place, it was one

way of combating his father. His father had refused to permit him to go to work and earn money for himself. Very well—he would obtain money by selling his father's property. In the third place, by providing him with money, this course of action enabled him to indulge his craving for the theater, which, as I have already pointed out, was very strong.

So he got into the habit of taking from the house articles belonging to his father and selling them to the peddler. A good deal of the money obtained in this way he spent in attending the theater. He never took property belonging to any one except his father, and the reason for this we can easily understand. He did not take things belonging to people outside of the family because that would have been plain stealing, and he was at heart really an honest boy. Property belonging to some one in the family, however, was in a sense partly his own, and he probably did not feel that he was committing any great sin in taking it. But he did not steal from his mother or sister because, to quote his own words, "they had very little and I had pity on them." His father, however, held the purse; he was the wealthy one of the family. Moreover, it was his father against whose authority he was in revolt and whom he felt impelled to get the better of in any way possible.

In behaving as he did, this boy was actuated by the same emotional forces that, under more favorable conditions, impel the individual to make those readjustments in his habits of thought and conduct that are required of him as he grows into manhood. In the present case, however, these forces, being poorly controlled and directed, served only to get him into serious difficulties. He was, as I have already pointed out, naturally timid and easily frightened. It is, therefore, not surprising that after stealing from his father, he began to worry about the possible consequences of his acts. He feared punishment. He learned that his father had talked to his teachers about him and had been advised to place his case in the hands of the Jewish Big Brothers. The boy knew very little about this organization and, in his fear and ignorance, pictured it to himself as some kind of a detective force that would have him followed and, if they found him doing anything wrong, would "send him away." Dogged by

his own fear and sense of guilt, he was always expecting to find the Big Brothers on his track. If people looked at him on the street, he thought they were shadowing him. He was always looking behind him. When he attended a moving-picture theater, he was in constant fear. After a picture had been shown and the lights were turned on for a vaudeville act, he would feel afraid that some one would see him. His heart would beat violently and he would look around to see if there were any one present who was going to get him. He always went out of the theater when a picture was being shown because then the house was dark. He would not go out when it was lighted because, if he did, he might be seen and made a prisoner.

It may seem strange, when he was so much afraid of the possible consequences of his wrongdoing, that he should have continued it. The tendency to continue doing something that is harmful to us, even where we are much concerned over the possible consequences of our acts is, however, a thing that we see every day in ourselves and in those about us; especially do we see it in those who, like this boy, are lacking in self-control. It is due to the fact that our conduct is not the result of our reasoning processes, although reason may modify it more or less. It is due to emotional forces that tend to find outlet in those forms of behavior to which we are predisposed by habit or innate tendencies. In fact, a man may seek relief from the emotional tension produced by a perception of the evil plight in which he finds himself by indulgence in the very habits to which, as he himself clearly realizes, his evil plight is due. Thus we find a man who is very much concerned over the state to which his bibulous habits have brought him going off and getting drunk as a means of relieving his feelings. I have known a boy to masturbate as a means of getting relief from the emotional tension that resulted from concern over his bad sexual habits.

In the present case, it would appear that one of the reasons why this boy stole and spent the money so obtained in going to the theater was because, by so doing, he was able to find a certain amount of emotional relief and more or less forget, for the time being, the unhappy situation into which he had been brought by the very practice to which he now turned as a

means of getting relief. His own words bear out this hypothesis. He says:

"I was afraid they would catch me, but I couldn't stop. I had the habit. I tried to stop; it forced me back again to take some more. I felt nervous when I didn't take anything. When I took something, I felt rather better, and when I went to the theater and spent the money, I felt better still."

The boy's fear of his father and the possible consequences of his wrongdoing finally caused him to run away from home. He had taken a watch from his father's desk, and after he had pawned it, he did not dare to return home. So he stayed away from the house until midnight and then tried to steal in unobserved after the family had gone to bed. But as he entered the apartment, he heard his father pounding on his desk. He concluded that he must be very angry. This frightened him so much that he at once slipped out of the house again and stayed away for three days, spending his time wandering miserably about the streets. As the weather was, at this time, too cold for sleeping outdoors, he would enter the subway in the evening and ride back and forth on the trains all night, getting what sleep he could. Finally, driven back home by hunger and fatigue, he stole into the house at night, after the family had retired, and lay down in the corridor, not even daring to go to his own room. The following morning, when the family arose, they found him lying asleep on the floor.

After his return home, he was so overcome with shame, on account of what he had done, as well as fear of the punishment that he expected to be meted out to him, that he could not bear to face his father, and when the latter attempted to interrogate him, he begged to be allowed to go into the next room, so that they could talk with the door between them. The average parent, in such a case as this, would probably have treated his son with a good deal of gentleness and consideration. This boy's father, however, gave way instead to a violent outburst of temper—threatened to choke him and said he would have him locked up. If these threats were made in order to deter the boy from indulging in any further escapades, they failed entirely of their purpose. In fact, they produced exactly the opposite effect, for his father's threaten-

ing attitude so stimulated his fear that, after he had been home only three days, he was impelled to run away a second time. This time he was absent four days, the last twenty-four hours of which he spent hanging about within sight of the house, anxious to return, but not daring to do so. His sister finally discovered him sitting on a bench in a small park across the street from where he lived, and took him home.

When he returned this second time, he was in a somewhat dull, stupid state, as a result of exhaustion and lack of sleep. His father, noticing this, absurdly supposed that it might be due to some drug and that this might also account for the peculiar way in which he had been behaving. He, therefore, proceeded to interrogate the boy along this line. Now the poor fellow was in a demoralized condition where he could easily have been induced to plead guilty to almost anything. Moreover, it seemed to him likely that, if his father believed that he had been acting under the influence of a drug, he would blame him less for his misconduct. He, therefore, admitted that his father's suspicion was correct. Pressed then for information as to the nature of the drug and where he had gotten it, he had to say something, so he said that it was a pink powder and that the Chinese laundryman had given it to him.

After these episodes, the boy felt so ashamed and distressed over his misconduct that he began to be quite seclusive in his habits. He could not bear to face his teachers and fellow students, who, so he believed, knew all about his troubles and the way in which he had been behaving. For this reason, he now remained away from school altogether. The same feeling of shame made him shrink from meeting his friends and neighbors, and his desire to avoid people led him to remain shut up in the house. His father, probably because he had begun to be seriously concerned about the boy's mental condition, now appears to have allowed him to do pretty much as he liked. So he spent practically all of his time indoors, held there a prisoner by his own feelings of shame and fear. In this prison of his own making, he had no amusement or occupation in which he could find satisfaction or emotional outlet. He, therefore, became more tense and irritable, his pent-up emotions finding outlet, on slight pro-

vocation, in violent bursts of temper, during which he would swear, throw things about, and smash articles of furniture. This tendency to fly into a rage was much aggravated by his elder sister, who was continually nagging him, calling him thief, crook, Chinaman, or flying into a rage herself and attacking him with her fists.

He was now in such distress that, when his father finally took him to a physician for a mental examination, he welcomed the idea of being committed to a hospital for the insane, as a means of escaping from his difficulties. He did not himself believe that he was suffering from a mental ailment, but he was very unhappy in his own home. He was ashamed to meet the people who knew him, and he saw in this step a means of getting away from an intolerable situation. Moreover, he was in deadly fear that some punishment would befall him for his wrongdoing—that the school authorities would have him arrested for playing truant, or that some one —the Jewish Big Brothers perhaps—would take action against him for having stolen from his father. So when he was examined by the physician and was asked if he could see figures on the wall, he said that he could, hoping that this would be regarded as evidence that he was insane. But the doctor apparently suspected him of lying, for he told his father that he was not insane, but merely "a bad boy." Later, when he was taken to Bellevue for observation, he suggested to his father that he should tell the physicians there that he took drugs, because he thought that, if they believed this to be the case, they would be more likely to keep him.

From Bellevue he was sent to Manhattan State Hospital, where he was admitted to the Psychiatric Service. His attitude in the hospital, as soon as he had gotten over his first feeling of strangeness, was one of intense relief at having escaped from the home situation and all the difficulties that beset him there. He was, on the whole, quite cheerful and well behaved, and did not show any of the irritability or violence of temper that he had displayed while in his own home. He was, however, a very timid boy and would worry excessively over trifles. For example, if he were summoned to the physician's office, he would at once begin to worry over all the unpleasant things that might be in store for him—the

possibility that he had done something wrong for which he was to be reprimanded or that the physician was going to transfer him to another ward—and he would arrive breathing rapidly and looking much perturbed.

He was at first inclined to be reticent about the events that led up to his commitment, but by the exercise of a little patience and tact, it was possible to get his confidence, and then he talked over his troubles with a fair degree of frankness. He manifested a good deal of shame and remorse in regard to his own misdeeds; frequently he would choke with emotion and his eyes fill with tears. Nothwithstanding the difficulties he had had with his father and sister, he showed no resentment toward them and never attempted to blame any one but himself. He said that he wanted to remain in the hospital for a time. The family was going to move to a different neighborhood in the course of a few weeks, and there the people would know nothing about him or his troubles. When the family got settled in their new home, he hoped to return to them, get his working papers, and go to work. He remained in the hospital for about four months and then returned home and went to work as he had planned. Since then he has gotten along fairly well, and apparently his family has had no further serious trouble with him.

Now the cause of this boy's psychosis—for I think we are justified in calling it by that name—was his failure to adjust himself to the new emotional forces that become active with the onset of adolescence. But why should he fail thus miserably in making an adjustment which most boys are able to make successfully? The fault lay primarily in his own personality—his hyperexcitability and lack of self-control, in the weakness of character that predisposed him to react to his difficulties in an unhealthy way. But much also depended on external circumstances—the treatment he received from his father, the unwholesome environment that made the task of adjustment unnecessarily difficult. There is little reason to doubt that if he had been properly handled from the first, the history of his case would have been quite different. A few talks with some one capable of understanding his difficulties and giving him counsel and advice would probably have been enough to modify his attitude and lead him to react to his

impulses in a better way. It might, however, have been necessary to remove him for a time from the home environment which was affecting him so unfavorably; for with this boy, as with so many of our unstable individuals, it is evident that the home was about the worst possible place for him.

This case has been presented as a concrete example to show what was meant by the statement made at the beginning of this article—that the mental disturbances so frequently seen in adolescence are due to the difficulty the individual encounters in adjusting himself to the demands of the emotional forces which become active at this time. It might now be well, for the sake of clear thinking, to state somewhat more definitely just what is meant by the term "mental adjustment." Mental adjustment may be defined as the process by which the individual is brought into harmony with his environment and the demands of his own nature. In order that we may be impelled to perform those functions required of us as individuals and as members of society, nature has given us certain appetites and instincts which, as a rule, give rise to useful forms of behavior. Sometimes, however, circumstances are such that it is neither possible nor desirable to gratify them. It is, therefore, fortunate for us that within certain limits we are able to modify and control these forces, so that they will not impel us to seek the impossible or bring us into conflict with our own best interests or the best interests of our fellows. A man is not in harmony with himself or his environment when the demands of his appetites or instincts are unsatisfied. To adjust himself, to restore this harmony, he must do one of two things: he must if possible so modify his environment as to obtain from it that which his nature demands, or he must modify his tastes and desires so as to bring them into harmony with that which is possible of attainment. Life is one long series of adjustments and readjustments, for we are constantly finding ourselves in new situations to which we must react either by modifying the environment to match our demands or by modifying our demands to fit them to an environment that we are unable to improve. Some people make these adjustments well. Some make them very poorly. For example, one resigns himself cheerfully to the inevitable; another, unable to modify the

demands of his nature to fit the situation, frets and chafes under it, or even is carried along by emotional forces he cannot control into unwholesome habits of thought and conduct, which may depart so far from the normal as to constitute a psychosis.

But it is in adolescence that the ability of the individual to adjust himself is, as a rule, most severely tried, for, as already pointed out, he has, owing to the new appetites and desires that now awaken, to make one of the most radical readjustments required of him at any period of his life, and in his efforts to make this adjustment, he is severely handicapped by his ignorance and inexperience. He has to deal with new emotional forces of great strength, but of the nature and significance of these forces he knows very little. He does not know whether they are good or bad, whether he should yield to them or hold them in check; so he is carried along by a blind impulse seeking some means of emotional outlet, some source of satisfaction. This outlet, this satisfaction, he must find in his dealings with his fellows, in work and play, in the adjustment that he makes with the world about him. But of this world, also, he as yet knows very little. He does not know how or where he may obtain from it the means of satisfaction which his nature demands. So he gropes his way, seeking more or less blindly some adjustment that will satisfy his needs, and in this blind groping there is great danger that he may fall into unwholesome or undesirable habits of thought and conduct.

But even where his impulses lead him toward a satisfactory adjustment, there is danger that he may be prevented from reaching it by misguided parents who have different views. His parents may exert their authority to prevent him from ordering his life as the needs of his nature dictate, forcing upon him instead a manner of life that is in conformity with their own views and desires, but that for him makes a satisfactory adjustment impossible. So we find that the weaker or less fortunate ones at this time are unable to adjust themselves. In some this failure to adjust shows itself merely in an emotional disturbance which may not swing beyond the limits of what we are accustomed to regard as normal. In others, however, it results in unwholesome habits of thought

and conduct, in bad sexual practices or antisocial acts, and in certain cases it manifests itself in types of mental reaction which we are accustomed to regard as manifestations of mental disease. Of these cases, some after a time are able to correct their unwholesome tendencies and ultimately succeed in making a more or less satisfactory adjustment; while in others the faulty types of thought and behavior, instead of being corrected, only become more fixed as time goes on. These cases usually end up in hospitals for the insane, where they are labeled "dementia praecox" and find their way to the chronic wards, there to spend the remainder of their lives.

In conclusion, I should like to point out that in preventing the development of these unhealthy types of mental adjustment, we have a very important field of work and one in which very little has as yet been done. We have at present an elaborate system of schools and colleges in which at great expense we cram the heads of the young with languages, history, and mathematics, but we do little or nothing to assist them in handling the vital problems of their own lives. There are very few boys, or girls either, who would not be the better for some assistance and guidance during the adolescent period. There is many a one with whom it would make all the difference between becoming a useful member of society and becoming a permanent inmate of a public or private institution. The time to deal with our functional disorders is before they have developed. We must prevent the development of such cases by helping the adolescent boy or girl to make a wholesome adjustment to the demands of his instinctive nature in the first place, for by the time he reaches a hospital for the insane, he has commonly departed so far from normal habits of thought and conduct that our attempts to reëducate him are of very little use. The biggest field for the psychiatrist in the future must be, not in the hospitals for the insane, but in the community at large. We must have psychiatrists in the schools, for commonly it is there that incipient mental disorder first shows itself. We must have more mental clinics, and as time goes on and the public becomes better educated in regard to the subject of mental hygiene, we shall also find a steadily increasing demand for competent psychiatrists in private practice to whom parents can bring their problems and receive assistance and advice.

MENTAL DEFICIENCY IN NEW YORK STATE*

Based on Findings of Army Medical Corps, Division of Neurology and Psychiatry

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ONE of the significant results of the medical examinations incident to mobilization of the army was the startling disclosure of the large percentage of young men who were disqualified for military service by reason of various physical and mental disabilities. Approximately 16 per cent of those examined were rejected. Of these rejections neuropsychiatric conditions were fourth in order of frequency, being exceeded only by diseases of (a) the eye, ear, nose, and throat, (b) bones, joints, and feet, and (c) heart and blood vessels, in the order named. Mental deficiency proved to be by far the most frequent neuropsychiatric cause for disqualification, representing about 31 per cent of these cases.

The rate of mental deficiency found among the men from New York State was 3.7 per thousand men examined. Taking the population of New York State as 11,187,798, it is estimated upon this basis that there are in New York over 40,000 mental defectives outside of institutions. This estimate includes males and females of all ages, and the calculation presumes that the rate represents the average incidence of feeblemindedness in the general population of New York State. It is interesting to note that 40,000 approximates very closely various civilian estimates and confirms the importance of the extra-institutional aspect of mental deficiency in New York State.

Up to May 1, 1918, detailed reports had been submitted to the Section of Neurology and Psychiatry of the Office of the Surgeon General in regard to 1,293 cases of mental deficiency

* Acknowledgment is due Mr. Roy Haber, ex-captain, S. C., U. S. Army, who supervised the compiling of the statistics upon which this article is based.

found among troops residing in New York State. These cases were reported from the various cantonments, general hospitals, recruit depots, aviation fields, and departmental and post hospitals. At each of the above stations, there were assigned to duty medical officers who were specialists in neuropsychiatry. All cases of nervous and mental conditions, including mental deficiency, were reported to the Surgeon General, and it is from these records, comprising over 70,000 cards and clinical reports, that the information in regard to the mental defectives from New York State has been obtained. It is the purpose of this paper to analyze the clinical and social data in these cases, commenting upon the various possible conclusions to be drawn from a study of the same.

TABLE I

Identification of Mental Defectives

	Number	Per cent
Psychiatrists in routine examinations	423	32.71
Referred by commanding officers	427	33.02
Referred by medical officers	404	31.25
Referred by psychologists	2	0.16
Referred by court	4	0.31
Unascertained	33	2.55
Total	1,293	100.00

The cases of mental deficiency were brought to attention through various channels, as shown in Table I. It is significant that one-third were referred to the neuropsychiatrists by commanding officers, as conduct disorder and inability to acquire the rudiments of military drill were frequent causes for investigation of the mental ability. Almost an equal number were found by psychiatrists in routine examinations. This constitutes a fair proportion when it is considered that by far the largest number of mental defectives were of the moron and border-line grades (see Table III), more difficult to isolate in the short routine neuropsychiatric examination. A slightly smaller number were referred to psychiatrists by general medical officers; in these cases the mental deficiency was often brought to light in the course of hospital treatment

for some intercurrent disease. Only a small fraction of the cases were referred by psychologists, the latter acting usually in conjunction with psychiatrists or occupied in the general classification possible by group tests. Likewise very few were referred by courts; evidently most of the delinquency to be expected from mental defectives had been anticipated and eliminated by early recognition of the feeblemindedness. In this connection, it is of interest to note that only fourteen cases were officially accused of misconduct. This small number may be accounted for by the supposition that many misconduct cases were not brought up on charges by commanding officers because the offenses were petty, but were rather presented for an opinion as to their mental status.

TABLE II

Length of Service of Mental Defectives Prior to Discovery of Their Mental Deficiency

	Number	Per cent
Under 1 month	452	34.96
1 to 3 months	386	29.85
4 to 6 months	192	14.86
7 to 12 months	86	6.65
1 to 2 years	29	2.24
Over 2 years	6	0.46
Unascertained	142	10.98
Total	1,293	100.00

About 65 per cent of the mental defectives were, as shown by Table II, recognized before they had been in the service three months. Here again one should take into consideration the high percentage of moron and border-line cases, making it likely that most of the mental defectives would not be isolated until conduct disorder or inability to learn had brought them to the attention of their officers. The fact that most of them were discovered after a short period of service speaks for the efficiency of the neuropsychiatric officers in eliminating mental defectives from overseas duty. Mental deficiency was a minor problem in the A. E. F., notwithstanding the fact that recommendations as to disposition of neuropsychiatric cases in this country were sometimes disregarded.

TABLE III

Classification of Mental Defectives

	Number	Per cent
Imbeciles	260	20.11
Morons	881	68.14
Border line	95	7.35
Unascertained	57	4.40
Total	1,293	100.00

The fact that a large percentage of the cases of mental deficiency were of a high or border-line grade has already been mentioned. It was to be expected that the local boards would eliminate the most obvious cases of mental deficiency, passing only those that required special examination or prolonged observation to determine their disability.

According to the conclusions of the British Royal Commission on the Care and Control of the Feebleminded, based on an extensive survey, the feebleminded at large may be classed as follows: idiots, 5 per cent; imbeciles, 20 per cent; and morons, 75 per cent. These figures approximate very closely those given in Table III, the question of idiocy, of course, not being met with in the army.

TABLE IV

Family History of Neuropathic Traits

	Number	Per cent
Positive	416	32.17
Negative	597	46.17
Unascertained	280	21.66
Total	1,293	100.00

For the information as to the family history of the mental defectives, the medical officers were almost entirely dependent upon the soldier himself, and there were probably many instances where the data secured were unreliable or at least incomplete. From the reports submitted, however, 32.17 per cent of the mental defectives from New York were found to have relatives with neuropathic conditions. This is undoubtedly a small proportion and does not coincide with

accepted figures, the discrepancy to be accounted for, as stated, by the restricted and unsatisfactory sources of information.

TABLE V

Ages of Mental Defectives

	Number	Per cent
Under 20 years	110	8.51
20 to 24 years	515	39.83
25 to 29 years	490	37.90
30 to 34 years	159	12.29
35 years and over	11	0.85
Unascertained	8	0.62
Total	1,293	100.00

There is obviously little room for discussion of the ages. The age groups were quite definitely limited by the draft regulations. One would expect that mental deficiency would not be found so prevalent in the higher ages, the latter being made up of officers and men longer in the service who were accustomed to army life and not so apt to be subjected to an examination.

TABLE VI

Home Environment of Mental Defectives

	Number	Per cent
Urban	965	74.63
Rural	321	24.83
Unascertained	7	0.54
Total	1,293	100.00

In considering environment, the reports of the U. S. Census were followed in classifying all places of 2,500 population or over as urban. Table VI may be compared with the census report for 1910, in which it was stated that 78.70 per cent of the population was urban or living in places of 2,500 or over. On the other hand, it was found that the counties of New York that gave the high percentages of mental deficiency to the army were those containing no large cities. It is conceivable that the greater facilities for isolating and caring for

mental defectives and the stress of competition in the cities, preventing to a large degree the migration of mental defectives from the country, would tend to cause a higher percentage of mental deficiency in the more rural districts.

TABLE VII

Degree of Education of Mental Defectives

	Number	Per cent
No grades completed	338	26.14
Completed 1 to 3 years	342	26.45
Completed 4 to 8 years	483	37.36
High school, 1 to 2 years	7	0.54
High school, 3 to 4 years	3	0.23
Unascertained	116	8.97
Foreign tongues	4	0.31
Total	1,293	100.00

The data as to education was obtained directly from the men by the neuropsychiatric officers. It is believed that there was a general tendency, under such circumstances, for the men to exaggerate their training, and if any error exists, it is that the facts were overstated. According to Table VII, about 90 per cent of the mental defectives had not reached the high-school grade, over 26 per cent having failed to complete any grade. The above may be compared with Table VIII, which shows the results of an examination of about 80,000 psychological records carefully selected by the Section of Psychology in the Office of the Surgeon General as a fair sample of the men in the army. Of the normal white men, only 3.2 per cent had no education, as contrasted with 26.1 per cent of the defectives.

TABLE VIII

Degree of Education of 80,000 Soldiers

	White per cent	Colored per cent
No schooling	3.2	13.5
Grades	75.2	76.0
High school	16.6	8.9
College	5.0	1.6
Total	100.0	100.0

TABLE IX

Economic Condition of Mental Defectives

	Number	Per cent
Marginal	1,213	93.81
Comfortable	39	3.02
Unascertained	41	3.17
Total	1,293	100.00

In compiling information on the economic condition, the cases were divided into two groups—marginal and comfortable. Persons were considered as being in marginal circumstances who were not able to live in idleness for four months without becoming objects of charity. It is quite significant that 93.8 per cent of the mental defectives were placed in the marginal group in view of the rather frequently expressed opinion that mental deficiency is an important etiological factor of economic dependency.

TABLE X

History of Venereal Diseases of Mental Defectives

	Number	Per cent
Admitted	179	13.84
Denied	1,114	86.16
Total	1,293	100.00

All the men were questioned as to venereal disease prior to army service, and unless there was direct evidence of the existence of infection either by physical signs or laboratory findings, the accuracy of the record depended upon the truthfulness of the individual questioned. Perhaps a too large percentage denied infection at any time, but it is believed that the statements were fairly reliable, there being no penalty attached to an admission of a gonorrheal or syphilitic infection in civil life. From the percentages in Table X, it is a question whether or not one should modify the popular opinion as to the extent of the hyper-sexual activity at least of male mental defectives.

TABLE XI

Alcoholic Habits of Mental Defectives

	Number	Per cent
Abstinent	472	36.50
Moderate	629	48.65
Intemperate	142	10.98
Unascertained	50	3.87
Total	1,293	100.00

Information concerning alcoholic habits was compiled from the statements of the men and the routine examinations. Over 85 per cent claimed to be abstinent or moderate in their use of alcoholic beverages, and apparently there were no facts or circumstances found to controvert these conclusions.

TABLE XII

Marital Condition of Mental Defectives

	Number	Per cent
Single	1,166	90.18
Married	114	8.82
Widowed	6	0.46
Divorced	2	0.15
Unascertained	5	0.39
Total	1,293	100.00

There appears to be little if any special significance attached to the statistics in reference to the marital condition. Single men were selected in greater proportion for service, and it is not at all strange that over 90 per cent of the mental defectives were not married.

TABLE XIII

Races of Mental Defectives

	Number	Per cent
African	42	3.25
English	164	12.68
French	23	1.78
German	121	9.36
Greek	7	0.54
Hebrew	91	7.04
Irish	129	9.98

TABLE XIII—concluded

Races of Mental Defectives

	Number	Per cent
Italian	189	14.62
Scandinavian	8	0.62
Scotch	6	0.46
Slavonic	138	10.67
Spanish	2	0.15
Mixed	309	23.90
Dutch	9	0.70
Other races	17	1.31
Race unascertained	38	2.94
Total	1,293	100.00

The table showing the races of the mental defectives in New York State is included without much comment. The question of race mixture in the United States is so complicated that no definite conclusions can be safely drawn. Of far greater importance is the nativity of the foreign-born mental defectives which appears in the following table:

TABLE XIV

Nativity of Mental Defectives

	White	Black	Total	Per cent
Native born	841	41	882	68.21
Foreign born	407	4	411	31.79
Total	1,248	45	1,293	100.00

According to the 1910 census, 69.85 per cent of the general population of New York State was native born, while 30.15 per cent was foreign born. Comparing these percentages with those in Table XIV, not a great amount of difference is found, there being, however, a slight increase in the percentage of foreign born among mental defectives.

Of the 841 defective native-born whites residing in New York, 398, or 47.32 per cent, were born in New York, the remaining 52.68 per cent being born in other states of the Union. This is strikingly different from the general population according to the census of 1910, only 11.29 per cent of the native-born whites residing in New York having been

born in other states. No attempt will be made to explain this apparent phenomenon of migration. In general, the facts are that out of a total of 17,406 cases of mental deficiency found among the white troops examined, only 483 were born in the state of New York. Of these, 398 were still residing there at the time of the draft and 85 had migrated to other states. While New York had given only 85 mental defectives to state migration, she received 443 in return. The same information among the blacks of New York is of little significance on account of the small number.

TABLE XV

Nativity of Foreign-Born White Mental Defectives

Country	Number	Per cent
Asia	2	0.49
Austria	25	6.14
Canada	5	1.23
England	2	0.49
Finland	1	0.25
France	1	0.25
Germany	5	1.23
Greece	5	1.23
Holland	3	0.74
Hungary	1	0.25
Ireland	16	3.93
Italy	170	41.77
Mexico	1	0.25
Poland	20	4.91
Russia	130	31.94
Spain	2	0.49
Sweden	2	0.49
West Indies	1	0.25
Others	15	3.69
	407	100.00

At the time of the preparation of this paper, there was available no authoritative information as to the total number, by country, of foreign born residing in New York State who were called for army service. For this reason, a complete analysis of the table showing the country of birth of the foreign-born mental defectives is not possible. It is, however, both interesting and suggestive that by far the greatest

number of these foreign-born mental defectives came from Russia and Italy. Incidentally, about the same ratio is found to exist in a study of the foreign-born neuropsychiatric cases in general throughout the army, making the question of immigration from Italy and Russia and its relation to neuropsychiatry in the United States a matter of great concern.

Taking the United States in general, the following states lost in the number of neuropsychiatric cases[1] either from immigration or migration or both: Iowa, Kansas, Kentucky, Tennessee, North Carolina, South Carolina, Mississippi, Alabama, and Georgia. The remaining states gained by migration and immigration, notably New York, as has already been shown.

Comparing New York with other states, there is a considerable variation in the percentages of mental deficiency found among the troops. In a paper on the incidence of mental deficiency in the United States as shown by the army medical examinations, Dr. Pearce Bailey has given in detail the percentage of mental defect found in each state. Among the whites for the entire United States, mental deficiency constituted 29.2 per cent of all the neuropsychiatric disorders. In nineteen states the percentages were larger and in twenty-eight states they were smaller than the percentage for the entire country; in two states they equaled that percentage. Arizona had the smallest, the percentage being 15.0. New York was sixth, with 19.9, equaling Illinois. Some of the other states were as follows: Ohio, 23.9; Massachusetts, 25.7; Connecticut, 26.8; Pennsylvania, 27.0; and New Jersey, 27.5.

Among the colored neuropsychiatric cases, the percentage of mental deficiency for the entire United States was 48.3. Seven states exceeded this figure. New York was seventh in the list with a percentage of 29.2. Florida had the least percentage, it being 11.5. Other states were as follows: New Jersey, 21.0; Massachusetts, 33.3; Ohio, 33.5; Illinois, 41.0; and Pennsylvania, 42.0.

It is important to consider briefly the general results of the identification and rejection of mental defectives from the military service. As Dr. Bailey pointed out in the paper

[1] Note: Not mental defective alone.

already quoted, the exclusion of mental defectives from military duty was highly desirable. Not only would the operations of an aggressive army be hampered by the presence of those who, through inability to acquire the rudiments of training or through temperamental defects preventing the proper adjustment to the environment, could not be absorbed in the army, but also, because of unreliability and judgment defects, the safety of their comrades would be actually menaced. As Dr. Salmon has said, it is far better for the mental defectives to remain in civilian positions, where many of them have been sufficiently well trained to be of positive economic value, than it is to waste the time and energy required to fit them for even limited service in the army. In the matter of delinquency alone it has been stated that there were required not one-tenth the accommodations for disciplinary purposes that had been anticipated and that the prohibition of alcohol and the elimination of neuropsychiatric conditions, of which mental deficiency was the chief, were the principal causes of this surprisingly creditable showing of the United States army.

The fact that mental deficiency was practically eliminated as a problem of the A. E. F. by the early identification and rejection in this country has already been noted. A comparison of the neuropsychiatric condition of the various armies at the front justifies in every way the special examinations by qualified medical officers.

What can be said in reference to the relation of immigration and mental deficiency in New York State? It has previously been stated that 31.79 per cent of the mental defectives in the army from New York State were foreign born. If the estimated 40,000 mental defectives outside of institutions are taken as a basis for calculation, there are probably now about 12,720 mental defectives in New York State who would have been kept out of the United States had the proper immigration laws been on the statute books or had the existing laws been more effectively called into use.

A like consideration of the question of state migration would make it appear that New York State had in this respect been even more unjustly burdened. It was stated before that 52.68 per cent of the native born, or about 35 per cent of the total white mental defectives from New York, were born in

other states. The greater number of these came from Pennsylvania, New Jersey, Massachusetts, Connecticut, and Ohio. But the total coming from these states numbered less than fifty. The remainder were from all states of the Union. To summarize, of the white mental defectives in the army from New York State, approximately 32 per cent were born in New York, 33 per cent in foreign countries, and 35 per cent in other states. If these percentages hold true throughout the state, a satisfactory solution of the question of immigration and state migration might result eventually in the settlement of a greater part of the problem of mental deficiency for New York.

Such theoretical speculations, however, are useless so far as immediate practical value is concerned. Of far greater importance is a realization of the extent of mental deficiency and of the fact that much may be done to ameliorate the situation by the establishment of the necessary intra- and extra-institutional facilities for the identification, treatment, training, supervision, and custodial care, when required, of all cases. A truly comprehensive plan, moreover, involves the identification of mental defectives at an early age, in order that proper habit formation may be assured and useful systematic educational training instituted. When the state, as a whole, is provided with special classes in the public schools; clinics for consultation and advice in cases of mental deficiency; an organized system of continued parole supervision, especially for those above the age limit for special classes; and well equipped institutions with sufficient accomodations for those requiring special training or custodial care, including defective delinquents, a long step will have been taken towards meeting effectively what will otherwise continue to be the "menace of the feebleminded."

DOES THERE EXIST A NEED FOR A PROGRAM OF EDUCATION IN MENTAL HYGIENE?

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WHAT has been taken to be a very important and necessary part of the mental hygiene movement is the dissemination of information pertaining to the varied aspects of mental hygiene. This program of education has proceeded upon the assumption that there are in the lay mind not only gross misconceptions regarding facts fundamental to mental hygiene, but even an almost complete ignorance of what should be common knowledge if the general public is to play its just part in a movement of this sort. The questionary upon which this report is based was devised with the hope of being able to determine as accurately as possible the validity of these assumptions and, in addition, to reveal what points, if any particular ones, should be emphasized to overcome current misconceptions and defects in the knowledge possessed by the lay public. A study of this nature should indicate the subject matter that is most needed and, as a valuable by-product, throw light on numerous questions vitally related to mental welfare.

The investigation was conducted in a state in which there is no organized mental hygiene society. Questionaries were sent to representative groups of citizens of the state, the groups being composed of 25 of each of the following: business men, clergymen, farmers, housewives, laborers, lawyers, trained nurses, practising physicians, university professors, university students, school superintendents, and public-school teachers. In all 300 questionaries were sent out. Excepting in the case of the professors and students, the forms were distributed as widely as possible throughout the state. The contents of the questionary will be made clear in the treatment of the results.

The number of questionaries filled in and returned by each

gives a suggestion of the willingness of the various groups to coöperate in work in mental hygiene. Out of the 25 questionaries sent to each group, the following were returned:

Business men	20
Clergymen	23
Farmers	19
Housewives	21
Laborers	12
Lawyers	18
Nurses	21
Physicians	17
Professors	16
Students	18
Superintendents	22
Teachers	21
Total	228

The difference between the groups is significant. The poorest coöperation was shown by the laborers and professors and the best coöperation by the clergymen and superintendents. It is difficult to tell whether or not the failure to coöperate on the part of the laborers was due to unwillingness or to an inability to comprehend what was wanted. In general the returns are extremely gratifying, especially when one considers that the subject matter of the questionary is unusual and is of the sort that is either taken as a joke or passed by without receiving the frankness it merits. In addition a few questions might be construed to be prying into the personal affairs of the recipients of the blanks and perhaps this kept the percentage of returns lower than it otherwise might have been. The cause for the large return seems to lie in the appreciation of the need for mental hygiene by those to whom the questionary was sent and also to the fact that an interested person was used in each community to distribute the blanks to acquaintances and solicit their return.

Since the several groups are not composed of an equal number of cases, wherever necessary for comparison in the detailed report that follows, the results are changed to a percentage basis in order that a more direct comparison may be made between the groups.

Of the 228 persons who contributed to the data, 101, or 44 per cent, had seen a person whom they knew to be mentally unbalanced at the time. Of these 60 per cent were afraid of the disordered person. There were, on the other hand, 127 who had never to their knowledge seen such a person, but of this number 88 per cent thought that they would have cause to be afraid of one who was insane. There is nothing striking about the distribution among the groups except that among the physicians and nurses the percentages of those who had at some time or another seen a mentally disordered person were but slightly larger than among the rest of the groups. Only 10 of the 18 nurses, or 55 per cent, had seen a case of mental disease; all of these had been afraid of the patient. Of the 17 physicians, 12 had been in contact with a case of mental disease, and 3 admitted that they had been frankly afraid. Most noticeable is the difference between the sexes. Of the 228 questionaries, 57 were supplied by women; 21 housewives, 21 nurses, 9 teachers, 5 students, and 1 physician make up this total. Among these, 43 per cent had seen an insane person and 92 per cent of the 43 per cent had been afraid; 97 per cent of those who had never observed a disordered person thought that they would be frightened if they were to come into contact with such a person. Acquaintance with the conduct of an insane person apparently has a disillusioning effect among all groups and the unwarranted fear of the insane is lessened.

To be insane was unqualifiedly considered a disgrace, either to the afflicted or to his relatives, by 114. Six qualified the reply; three—1 physician, 1 clergyman, 1 housewife—said that it depended upon the cause of the disorder; 1 university professor said it was a misfortune to some and a disgrace to others; 2 said that mental disease was *sometimes* a disgrace. Only 4 of the 23 clergymen and 2 of the 17 physicians considered mental disorder a disgrace. Two of the clergymen gave no reason why they thought it a disgrace in itself to be mentally afflicted; of the remaining 2, the "notoriousness of their conduct" was given by one, while the other stated that insanity was the result of excesses and therefore a disgrace. One physician gave no reason for the presence of the stigma of disgrace, and the other thought

insanity disgraceful because it indicated inferiority. The chief point made by the qualifications was that when the disorder was the result of one's own misconduct, it should reflect back upon the afflicted, while one housewife thought it a disgrace to a person if "the Almighty should show His anger with some one." There were 14 who recognized that there is an unwarranted stigma attached to the insane.

Closely related to the idea of the disgrace which some consider to be attached to the presence of mental disorder is the secrecy with which some would shroud a case of mental disorder in their immediate family. Asked if they would attempt to keep the matter secret if they felt fairly certain their minds were giving way, 186 gave affirmative replies, 12 were noncommital, and the remainder would not attempt secrecy, but at the same time there were 8 who would not give the matter any more publicity than was necessary. With the exception of 8, all those who considered insanity a disgrace would shroud a case in secrecy. The same question with reference to the presence of a disorder in a relative brought replies identical with the above except that 8 of the 186 would take into consideration the wish of the afflicted and 1 physician would use as a guide the probable cause of the disease.

Only 9 of the 228 persons would not dread being insane. The reasons most frequently given for this dread were disgrace to relatives, burden to the state and dependents, inability to enjoy life, object of ridicule, worthlessness, and numerous miscellaneous reasons that would not come under the above classification. Such were: "Not being able to control my thoughts and actions;" "Living as an animal or lower;" "Might kill some one;" "Do not wish to be unusual in any way;" "I dread any disease;" "There is a certain family pride;" "Might cause other people to go crazy." One laborer stated that he would lose his job if he should lose control of his mind, and 1 professor stated facetiously that he probably would not dread it if he were insane.

The most bizarre notions were expressed as causes of mental disturbance. Almost everything from complexion to the malicious influence of mysterious forces was mentioned. In the following table an attempt is made to group the varied

ideas under as inclusive and self-explanatory heads as possible:

Cause	Number of times given
Physical injury	24
Emotional disturbances (grief, love, revenge, anxiety, etc.)	49
Religion	12
Business	8
"Nervousness"	14
Pregnancy and confinement	4
Introspection	3
Disease[1]	9
Ill health	12
Defective development	5
Involution	3
Hypnotism	3
Evil influences	1
Lack of confidence	3
Alcohol	17
Syphilis	10
Heredity	19
Brain structure	7
Overwork	11
Complexion	1
Epilepsy	3

There were 36 who made no attempt at all to give even what they thought might cause mental disorder. The causes as given by the 17 physicians are as follows:

Cause	Number of times given
Disease	8
Emotional disturbances	5
Syphilis	6
Physical injury	11
Pregnancy	1
Epilepsy	2
Brain structure	6
Alcohol	3
Heredity	2

Only 16 of the nurses attempted to list a cause. The following were given by this group:

[1] No specific diseases were mentioned, except typhoid fever by 1 physician. The phrase "severe sickness" was used by 4.

Cause	Number of times given
Disease	2
Emotional disturbances	9
Syphilis	1
Pregnancy	1
Nervousness	3
Heredity	2
Overwork	1

The great characteristic of all the returns on this question was the paucity of causes given by each individual. Using the above classification as a basis, the number of causes given by each may be grouped as follows:

89 gave 1 cause
56 gave 2 causes
34 gave 3 causes
7 gave 4 causes
6 gave 5 causes

Recovery from an attack of mental disorder was considered impossible by 155 of those who replied; 21 thought that recovery might be possible in isolated cases; of the remaining 52 there were 14 who considered recovery very probable.

There were only 85 who thought the occurrence of mental disorder preventable and of these 39 gave no clue as to the means of prevention. Regarding the means of prevention, 21 merely suggested, "Remove the causes." A change in environment was suggested by 5, abstinence from alcohol by 14, sterilization by 3, and varied and entertaining measures, such as the prevention of childbirth, recourse to Christian Science, and moderation in religion and love, by 10.

With only 27 exceptions, all thought that mental disorder had a part in the causation of various pathological social phenomena such as poverty, crime, prostitution, etc. Asked to rate the relative importance of the mental factor in the causation of these phenemona on a scale of 0 to 5, 0 being no cause and 5 total cause, the following results were obtained:

27 ranked it 0
19 ranked it 1
33 ranked it 2
84 ranked it 3
51 ranked it 4
14 ranked it 5

There were 27 individuals who thought that an insane person should be held accountable for acts committed while mentally deranged, while 14 qualified their reply to make it understood that they did not wish it inferred that they believed in using the insanity plea in the court room, as it is in many sensational trials. The remainder unqualifiedly felt that the insane should not be held responsible.

Thirty-one did not consider it dangerous for a mentally disordered person to be at liberty, while 23 others qualified the reply, limiting the danger to certain types of mental disorder.

The verdict was almost unanimous that persons who are mentally different from most people are also physically different and have a different appearance. There were 196 who thought that insane persons appeared different from the usual run of mankind and only 8 thought that they did not depart far from the normal in appearance. Asked to tell in what way the mentally disordered looked different, if there were any difference, the following results were given:

Differences	Number of times given
"Wild look"	24
Appearance of eyes	89
Gait and bearing	63
Facial expression	57
Clothing	9
General appearance	16
Miscellaneous oddities	8

There were 96 who considered that there is a distinct line that separates the mentally normal from the abnormal, and 104 who differentiated between the terms "feebleminded" and "insane." Forty-six merely stated that there is a difference between the terms and ignored the request to state the difference if there were any. Fifty-four made distinctions as follows:

Distinctions	Number of times given
Feeblemindedness is a mild insanity	14
Feeblemindedness is a severe insanity	6
Feeblemindedness is lack of development	23
Feeblemindedness is acquired in old age	5

Distinctions	Number of times given
A feebleminded person is " off on just one subject "	2
The feebleminded are not as dangerous as the insane	1
The feebleminded do not " look so wild " as the insane	1
The feebleminded lack character	2

It is impossible to tell what the remaining 4 were trying to state. All of the physicians differentiated between the two terms. Ten made the commonly accepted distinction; 3 stated that feeblemindedness was a mild mental disorder; 2 said that it was acquired in old age; 1 said that feeblemindedness was the same as "monomania;" 1 failed to state the distinction.

In reply to the question what signs or symptoms might indicate the presence of a mental disorder, the following were given with the frequencies indicated:

Symptoms	Number of times given
Nervousness	8
Emotional disturbance	49
Appearance	25
Wild actions	54
Speech disturbances	21
Reflex disturbances	2
Stigmata of degeneracy	12
Hallucinations	4
Delusions	12
" Crazy notions "	21
Appetite	3
Boorishness	3
Irritability	3
Miscellaneous	8

Comparing these results with those obtained under the causes of mental disorder, it is noticeable that several of the rubrics are repeated as symptoms. The number of symptoms given by each person is also small, over one half of the replies listing only two things that might indicate the presence of mental disorder. The returns from the different groups present nothing unusual except that the physicians listed slightly more causes and in general were more accurate and specific. They tended more toward the physical, however,

than did the other groups. The following are the symptoms as given by the nurses and physicians:

Symptoms	Number of times given By nurses	By physicians
Nervousness	2	1
Emotional disturbances	2	2
Appearance	1	1
Speech disturbances	1	3
Reflex disturbances	1	1
Stigmata of degeneracy	..	5
Hallucinations	2	2
Delusions	3	4
Appetite	..	1
Irritability	..	1
Poor memory	..	1
Chorea	..	1
Sex perversions	..	2
Undressing in public	..	1

There were 84 who conjectured, as implied in the reply, that there was more than one kind of mental disease, 29 were certain of several types, and 31 thought that there was only one kind of insanity.

Of the 228, only 52 had ever visited a place where mentally diseased persons are treated. State hospitals had been visited by 32, county homes by 18, and 2 had visited a private sanitarium. Many undesirable and unjustified impressions had been carried away by these persons, but in order to compare these impressions with the conceptions held by those who had never visited such a place, the results from both are given, reduced to a percentage basis: Of those who had visited a hospital for the insane, 46 per cent retained unfavorable impressions; of those who had never visited such a hospital, 81 per cent held unfavorable conceptions.

It is obvious from these results that those who have not visited a hospital for the insane entertain a large number of entirely erroneous and positively harmful conceptions of the nature of such a place. Even among those who have been through a state hospital there are many who retain undesirable ideas which have no objective validity at the present time. The writer has personal knowledge of people who have visited one of the best managed and most pleasant institutions

in this country, concerning which no undesirable impression could have been justified, but who still retain all their preconceived notions—in fact go away feeling that their terrible and gloomy apprehensions have been confirmed. There is no objective justification for such opinions. What, then, is the cause? Can it be the subjective bias produced by medieval notions? If so, public opinion can be so molded as to overcome this bias.

Almost half of the 228 persons did not know of any provisions made by the state for the care of the insane. The legal provisions were briefly sketched by 9 of the lawyers, 5 of the physicians (there were 3 more of this group who stated that it was necessary for a physician to appear before the patient could be placed in a custodial institution), 2 of the superintendents, and 1 of the housewives. The care of the insane in county homes was mentioned by 22; 47 mentioned one state hospital; 41, two hospitals; 12, three hospitals; 9, four hospitals; and only 6—among them only 1 of the 17 physicians—knew of the new psychopathic hospital which is being erected in connection with the state university. Of the 9 lawyers who did not briefly outline the legal provisions, 2 simply stated that the state kept the insane in custody, and the other 7 did nothing further than name one or more of the state hospitals.

The question, "If you felt fairly certain that your mind was giving way, where would you go for reliable advice and guidance?" brought these results: 159 would go to a physician; 38 would go to a specialist; 12 would go to the insane commissioner; 8 would see a lawyer; 3 would write to a state hospital; 2 would go to their spiritual adviser; 6 failed to reply.

The same hypothetical question with reference to a relative brought results identical with the above, but in addition there were included the following: 3 would take the relative for a trip; 2 would try to reason with the relative; 2 would attempt to provide a change of thought.

Only one person of the 228 who contributed to the data knew of the National Committee for Mental Hygiene. This was a housewife who is active in a woman's club in a small city of the state. The W. C. T. U. was mentioned by 5 as

doing work in mental hygiene, the Y. M. C. A. by 2, and the State Medical Society by 1. No other organizations were mentioned as doing work for mental hygiene.

Questions regarding the need of organized work for mental hygiene in the state and the willingness to take part in such work brought the following results:

Group	Number who replied	Recognized the need		Willing to coöperate	
		Number	Per cent	Number	Per cent
Business men	20	18	90	12	60
Clergymen	23	22	96	20	87
Farmers	19	15	79	10	53
Housewives	21	18	86	15	71
Laborers	12	7	58	2	17
Lawyers	18	15	83	10	56
Nurses	21	18	86	17	81
Physicians	17	12	71	3	18
Professors	16	11	69	10	63
Students	18	14	78	9	50
Superintendents	22	21	95	20	91
Teachers	21	19	90	17	81
Total	228	190	83	145	64
Average		16	81	12	60

The results have been presented with as little comment as possible for the deductions and conclusions are obvious. There is but little variation from physician and university professor to farmer and laborer. One is almost as well qualified to instruct in the topics touched upon by the questionary as the other. That there is a real need among these 228 persons for instruction in these topics is apparent. Can this small group be taken as representative of the bulk of the population of the state or the country? The implications which this material has upon any extensive or intensive work in mental hygiene are obviously numerous and far reaching, but it is not within the province of the present report to consider their utilization.

NERVOUS AND MENTAL DISORDERS OF SOLDIERS

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AT the hospital at Savenay there was an opportunity to observe nervous and mental symptoms that was probably unsurpassed in any of the forces engaged in the war. All cases, except those evacuated through England, were grouped for return to the United States at this point. All types, therefore, were encountered, and in numbers quite exceeding those seen in any similar centers in civil life. Numerous unusual conditions were observed. Types were seen which did not conform to those that are so familiar in civil life, and it may be said, particularly in respect to the purely mental cases, that the ordinary disorders of civil life were conspicuous by their comparative infrequency.

Lest any misapprehension should arise, however, as to the frequency of occurrence of nervous and mental symptoms in soldiers, it should be stated as a noteworthy fact that, considered as a whole, the mental attitude of the soldiers of the Expeditionary Forces was to a high degree that of normal and healthy men. Just as one was impressed by their physical vigor and hardiness, so in general a healthy and stable mental attitude was observed. This was true of at least 90 per cent of the men.

But it should not be inferred from this assertion that difficult adjustments were not encountered by the men of the army. A nation could not be confronted with all the emotions incident to the greatest war in history without a marked emotional reaction. Then when we consider the intimate association of different nationalities in the United States Army and the sudden alteration in social relationships between men, it is obvious that adjustments of an extreme degree were necessary. In view of the hardships unavoidable in any campaign, the delays in mail and pay, added to physical and nervous exhaustion, it takes little imagination

Administration Building, Base Hospital 214

Ward 1, Original Base, Base Hospital 214

to understand the state of mind in which many men found themselves. Incidentally it may be said that nothing could more conclusively prove the unity of purpose of these men and their faith in the right of the cause for which they entered the war than the patience, the fortitude, and the determination that they displayed throughout.

To attempt to interpret these mental and nervous manifestations in soldiers in terms of civil-life conceptions would manifestly be ill-advised. Men have been subjected to emotional experiences heretofore unknown. The magnitude of the war itself, shaking as it did the very foundation of institutions and established customs, made a deep impression upon all who came under its influence. It is, therefore, in the sphere of purely mental reactions that the most unusual conditions were found. The nervous states and the neuroses, arising as they did from anxiety and anticipation, at times associated with physical exhaustion, conformed more closely to what is seen in civil life.

As stated above, all nervous and mental cases of the American Expeditionary Forces, with few exceptions, went through this hospital for evacuation to America, and therefore, since it is improbable that before the war these cases have been cared for in such numbers under similar circumstances, a discussion of administrative affairs—such as buildings occupied, personnel engaged, and transportation of patients—will probably be of interest. A resume of the clinical material is subsequently given.

Administration of the Neuropsychiatric Service

Until November 6, 1918, the Neuropsychiatric Service at Savenay was under the direction of the commanding officer of Base Hospital 8. It functioned separately with a chief of service, medical staff, and special personnel. For the first six months comparatively few cases were admitted, the admissions being 369 from January 1st to June 1st, 1918. Two wooden barracks of ninety beds each were used during this period. The mess was with other patients. One ward was partitioned off, one end being used for disturbed patients.

After June 1, 1918, the admission rate rapidly increased

and additional wards became necessary. Three more wooden barracks were used as required for this service, providing accommodations for about 500 patients. In the meantime, specially constructed wards designed by the chief surgeon had been erected for this service in a locality some distance from the main hospital. These eleven wards, situated on a slight elevation of ground, consisted of the administration building, a ward for officer patients, a mess hall, a barracks for enlisted personnel, and a ward for disturbed patients, the remaining wards being of uniform type, with a large day room, shower baths, and running water. This unit was occupied in the latter part of August, 1918. There were accomodations for something less than 200 patients, but by using officers' barracks and enlisted men's barracks, the capacity was expanded to over 250. During this period, however, the barracks connected with Base Hospital 8 were still retained.

In October, 1918, four additional buildings of concrete block were added to the eleven wards above mentioned. When these were completed, the original barracks of Base Hospital 8 were relinquished. No diminution in the admission rate after the cessation of hostilities occurred, and therefore the unit as finally constructed proved inadequate. Indeed, in the late fall of 1918, admissions were so rapid that the commanding officer of the Center found it necessary to designate wards from two adjacent units—i. e., Base Hospital 69 and Base Hospital 113—for the temporary use of the Neuropsychiatric Service.

On November 6, 1918, the Neuropsychiatric Service was organized as an independent unit, taking over the quarters already occupied. The former chief of service was designated as commanding officer, and Major Joseph Betts became chief of service.

During the latter part of December, evacuations had been so rapid and admissions delayed to such an extent that for a short time there were but 65 patients in the hospital. Admissions, however, soon increased, so that early in January, 1919, the population exceeded 700 patients, including 40 officers. This was quite in excess of the hospital's capacity, especially since, except as a temporary expedient, the use of the wards of adjacent units was not feasible. Under these

circumstances the commanding officer of the Center gave directions that one of the new 1,000 bed units be taken over as a neuropsychiatric hospital.

In the period during which this organization was being changed from the Neuropsychiatric Service of Base Hospital 8 to an independent unit, and during the subsequent transfer of the hospital to its present site, considerable administrative work was necessary. Occasion is taken at this time to state that all the personnel connected with the organization carried out their duties in an exceptionally capable manner. The responsibility of this reorganizing and of the subsequent transfer of the patients and property, as well as the opening and equipping of the new unit, rested particularly with the chief of the service, the quartermaster, and the officer in charge of administrative details. These officers—Major Arthur H. Ruggles, Captain Royal C. Cannady, and Captain Charles S. Little—performed this work successfully under exceptionally difficult circumstances.

The new unit was occupied January 21, 1919. The construction was not completed and special construction was necessary; this was done chiefly by patients. A sitting room was made in one end of the officers' ward and furnished by the Red Cross. A similar sitting room for nurses was arranged in another ward. A staff-conference room was constructed in the officers' barracks. A diet kitchen, furnished by the Red Cross, was installed in the building used for occupational therapy. Four wards were constituted closed wards with screened windows, and in these wards partitions were constructed in such a way as to make patients' day rooms. One ward building was utilized for a Red Cross recreation hut and appropriately furnished.

The large building adjacent to the mess, used in other units for surgery and dressings, was fitted up for a workshop. This workshop was especially well equipped. It had the advantage of the use of material formerly used at Base Hospital 117, consisting of brass-work tools, lathes, carpentering sets, and an acetylene welding apparatus. Looms for weaving were made by the patients, and woven bags, belts, and mats were manufactured. A forge was made by one of the patients. A supply of salvage material for use in the shop was secured from the

salvage department at Tours. Six aids, under the direction of Miss Meta Anderson, were engaged in giving instruction. The average number of patients engaged daily was 42. A large amount of material of various kinds was manufactured in this shop. Much of this material—such as benches, tables, chairs, cabinets, and office furnishings—was used to equip the administration buildings and the wards of the unit. In the metal department rings, trays, and other souvenirs were made in great numbers. A considerable amount of material made was taken home by the patients.

Personnel: Prior to June 1, 1918, the Neuropsychiatric Service at Base Hospital 8 was under the direction of Major Charles D. Humes, who had from two to three assistants during this time. Major Humes succeeded in securing the services of nurses and enlisted men with special training in this work. On the 8th of June, 1918, Base Hospital 117 arrived at Savenay from the United States, en route for LaFauche. A part of the personnel—namely, three medical officers, twenty-eight nurses, and thirty-three enlisted men—remained at Savenay to take charge of the service, Major Humes being relieved and returning to his former station as consultant in neuropsychiatry at Vittol Center.

The organization, therefore, after June 8th consisted of four medical officers, twenty-eight nurses, and thirty-three enlisted men; fifteen of the twenty-eight nurses were on general duty with Base Hospital 8. This small service almost at the outset suffered a severe loss by the death of one of its most valuable officers and one who commanded the highest respect of all associated with him. Major Morris J. Karpas, who had joined the unit in Allentown, died suddenly on July 4 of angina pectoris. His loss was deeply mourned, not only by the members of the organization, but also by many of the officers and personnel of the Hospital Center, who had known him either personally or by reputation in civil life.

After June 1, 1918, the admission rate increased rapidly. In June 256 cases were admitted; in July, 405; in August, 588; in September, 887; in October, 658; in November, 809; in December, 412; in January, 1919, 885; and in February, 824.

The organization received the cases, classified them,

View of Ward 21 (closed ward), Base Hospital 214

View of Ward 7 (open ward), Base Hospital 214

afforded appropriate care and treatment, and furnished medical officers and personnel to transport them to the United States. Moreover, the trained personnel was sent to convoy patients to Savenay from other centers and organizations. It will be readily seen that demands on the enlisted men were very great, and no praise is too high for the valuable service rendered both by nurses and enlisted men during this period.

For purposes of classification, all patients were admitted to one large admitting room of ninety beds. A special nursing force was maintained here, and observations for classification were made at once. The organization was most fortunate in having with it Mrs. Janet Cranston, who had had experience in charge of the Psychopathic Department of Bellevue Hospital, New York. Captain John J. Hughes was in charge of the receiving ward, where considerable experience and judgment was necessary to classify these cases properly. All patients, upon admission, were seen by the receiving officer and assigned to proper wards. The acute psychoses, cases of chronic alcoholism, and delinquents were sent at once to closed wards. Mild psychoses, epileptics, and mental defectives were kept in open wards under supervision. Cases of psychoneuroses were sent to separate wards and, as soon as space was available, to the specially constructed wards mentioned above. These wards were under the charge of Major Henry W. Swift.

By examining and classifying at once every case, administrative difficulties were reduced to a minimum. During this period but two serious accidents occurred, although delinquents of every description came through the service. At the same time patients were given as much liberty as possible—indeed, liberties that in civil life would have been considered impossible. There was no separate mess for many months, patients going to the general mess. The Center Red Cross recreation hut was used by all, and the convalescent patients from the Neuropsychiatric Service often contributed very considerably to the entertainments.

The transportation of these cases to America was supervised by this organization to the extent that it furnished medical officers and enlisted personnel. The convoys consisted as a rule of from 50 to 200 cases and occasionally more. They

went by train to Brest or Saint Nazaire for embarkation, the patients being loaded in cars especially designated, with acute cases in one special car. The number of attendants sent varied according to the types of patients. The train left the hospital under the charge of a designated medical officer, who exercised supervision until the patients arrived at their destination in the United States. Such convoys drew heavily upon the personnel. This work could have not been carried on had it not been supplemented from the Hospital Center.

Clinical Summary

A large amount of clinical material passed through this hospital, no less than 6,093 cases having been admitted up to March 1, 1919. Observations were necessarily incomplete, and the recording of cases was impossible. The various types, some quite unusual, came under observation with such frequency that they became fairly familiar, and therefore clinical pictures, which otherwise would have been uncertain, became well established. It will be best to discuss the clinical material under the following headings:[1] Psychoses, Psychoneuroses, Epilepsy, Constitutional Psychopathic State, Mental Deficiency, Organic Nervous Diseases.

Psychoses: The number of frank psychoses, amounting in all to 1,916 cases, is probably not excessive, considering the forces engaged. Interest in these cases is more in their clinical character than in their numbers. It was soon observed that, in addition to ordinary civil-life types, many unusual cases were encountered. It is true that many cases of dementia praecox, general paresis, and other familiar diseases were admitted throughout this period, but they were not the only types seen. Soon after active hositilities began, cases appeared with which the staff were unfamiliar from their civil-life experiences, and in these unusual cases the reactions and the clinical pictures did not conform to any recognized types. It is possible that a number of these unusual cases would have been made more clear by adequate previous histories and longer periods of observation. This,

[1] The number of cases in each class is given in Table II at the end of this article.

Officers' Recreation Room, Base Hospital 214

Interior of Nurses' Recreation Hut, Base Hospital 214

however, was not true of all, and so it is considered that a tentative formulation of these unusual cases should be given at this time. They probably do not form a distinct class from every point of view. They doubtless have a common etiology, however, and they have groups of symptoms in common which are sufficiently striking to warrant their being discussed as a group. Such cases at this hospital have been referred to as "war psychoses," and so this term is somewhat arbitrarily used.

These cases of so-called war psychoses were observed in considerable numbers. No actual record of their number was kept, but they probably amounted to one-fifth of all the cases diagnosed as psychoses. Many of them improved considerably while at the hospital, and it is quite probable that by the time they reached the United States, the acute symptoms had disappeared. Such clinical descriptions as can be given here, therefore, although incomplete, may be of service in checking up with observations made elsewhere.

The following clinical picture is a composite of what was most frequently observed. Patients on admission were dazed, confused, and disoriented, and as a rule they were not accessible during the acute period. They generally thought themselves at the front under fire, and were anxious and apprehensive. They wandered about rather aimlessly and showed bewilderment and confusion. Some were quite agitated. Frequently they preferred to be by themselves and volunteered very little in the way of conversation. As a rule they were depressed, at times profoundly so, to the extent of making suicidal attempts. A few cases were observed in which there was an elevation of mood. The possibility of a manic-depressive condition was considered in these particular instances, but was regarded as improbable. In this general setting of clouding of consciousness, confusion, and bewilderment, there were active hallucinations of sight and hearing. Patients complained of seeing shells bursting and of hearing the whistling of shells and bullets. In their highly emotional state it is probable that a part of this was a misinterpretation of noises about the hospital. The symptoms were worse at night, but were by no means confined to the nighttime. This general condition had some features in common with the psy-

choneuroses, such as anxiety, fearful dreams, visual hallucinations, but the condition differed in that the patients were inaccessible, disoriented, and confused, with marked mood changes and no insight. Not infrequently there were delusional ideas of a transient character and of a changing nature, the content of which had to do with war experiences.

The interpretation of the nature of the conditions above described presents a number of difficulties. In some respects they resembled states of protracted exhaustive delirium. The English have designated these cases as acute confusional psychoses. It is thought, in view of the anxiety, the depression, the character of the hallucinations, and the emotional conditions, that emotion and excitement played quite as prominent a part in them as exhaustion. Since patients as a rule were inaccessible, no clear idea could be gained as to what they had experienced. It is possible that many of them had been under heavy shell fire, but in what circumstances cannot be stated. It was necessary to return these patients to the United States as soon as their condition warranted transportation. The impression here was that the prognosis was good. The psychosis was considered an acute one, having little in common with ordinary civil-life types, although many cases bore the diagnosis of dementia praecox on their admission tags.

Another small group of cases observed somewhat resembled those above described, but differed in a number of respects. Such patients were admitted in a delirious condition. As a rule they had not been at the front, possibly having but recently landed in France. They were confused, rambling in conversation, inaccessible, and restless. They were disoriented and presented the picture of delirium. The thought content was not remarkable. The condition was considered an hysterical delirium, arising in predisposed individuals.

Of the well-known psychoses, such as dementia praecox, manic-depressive psychoses, and others, a few features of interest were observed. A number of cases of dementia praecox appeared to have developed since enlistment. Some gave a history of symptoms previous to enlistment and a fair proportion of these had had previous hospital residence. Of the manic-depressive cases there were relatively more with depression than with elation. Both showed a war coloring,

especially the depressions, and, in fact, the thought content of many of the self-accusatory and depressed patients had to do solely with war conditions. They frequently had the idea that they were being accused of betraying their country or of being German spies. It is a noteworthy fact that comparatively few acutely maniacal cases were encountered. Their management was not as difficult as had been anticipated, although several very acute cases were admitted.

Psychoneuroses: No attempt will be made to discuss in detail the psychoneuroses in this report, not only because this would be beyond the limits of this record, but also because more favorable opportunities were offered at the other neurological hospitals for the observation of these cases. As a rule, when such patients reached this hospital, their symptoms had existed some weeks and even months, and so they presented clinical pictures differing in character and degree from those seen in the advance section. Only observation as to the general character and disposition of these cases as it pertains to this hospital will be made at this time.

It is probable that no cases that came under the care of medical officers were as imperfectly understood at the beginning of hostilities as the psychoneuroses. It is true that full information regarding them had been sent from the chief surgeon's office, and data of great value was likewise available from both French and British sources; nevertheless, the nature of these conditions was unfamiliar to most medical officers, and for this reason a number of weeks elapsed before the plans that had been carefully arranged beforehand for the care of these patients were in satisfactory operation.

During the early period of hostilities, as stated above, the psychoneuroses did not always come under the observation of the officers designated to take care of them. Some of these patients were sent from advance areas directly to base hospitals, where they were admitted to the various wards of the medical or surgical service. The fact that the case was a neurosis and not a physical disease was not always appreciated. They were retained in base hospitals without improvement, and many of them eventually arrived at Savenay for disposition. A number of others were classified by medical boards at base hospitals, sent to training camps when not

fully recovered, and, being found unfit at these places, were transferred to Savenay.

It can readily be seen that these cases, while relatively few in number, were unfavorable types for early recovery. Fortunately their number was not great, and in a short time steps were taken by the chief surgeon to have cases sent to their proper destinations and not immediately to base hospitals in the Service of Supplies. The excellent results, as evidenced by the reports of the work done by the neurological hospitals in the advance areas, indicate the comprehensiveness of the plans as originally constituted. The general management of the psychoneuroses of the war, as demonstrated by the results accomplished, emphasizes the fact that, to be successfully treated, such cases must be fully understood. The proper treatment of these conditions has been one of the most difficult problems confronting the physician in civil life. While it is true that they have always been understood by a number of physicians, it must be admitted that as a rule too little knowledge of them is gained by students in medical schools, and the fact that they are disorders in the functioning of the mind and not of the body is not always fully appreciated.

During the period of active hostilities, the number of cases of psychoneuroses arriving at this hospital was not relatively large. Two general types were recognized—those resulting from battle experiences and those of ordinary civil-life type, the latter of which had probably existed prior to enlistment. The civil-life types, such as neurasthenia and psychasthenia, as a rule came under observation soon after arrival in France and never reached the front. A certain portion of these were classified for duty in the Service of Supplies, and the more severe cases were returned to the United States.

The psychoneuroses arising from battle experiences came from two main sources. At one time a number came from base hospitals or reclassification camps, not having previously had special treatment. It was possible to return a considerable number of these cases to duty, and some were sent to Base Hospital 117. Other cases came from neurological hospitals in the advance section, mainly from Base Hospital 117. Cases arriving from these hospitals were intended for evacua-

tion to the United States, being considered constitutional types with an unfavorable outlook for recovery in the immediate future. After hostilities ceased, arrangements were made by which the psychoneuroses of all sources eventually came to this hospital, and this accounts for their increase in number during the latter months of this report. It was not the policy after the armistice to classify these cases for limited service, and therefore they were returned to the United States for disposition, the severe cases undergoing a period of treatment here before evacuation.

One feature of the symptomatology observed in this hospital was probably not seen elsewhere. It was found that a number of cases of mental deficiency, epilepsy, and mental diseases exhibited war neuroses, such as mutism, tremors, or hysterical hemiplegia. This association of symptoms was not infrequent, and these cases presented very unusual clinical pictures as a result.

Epilepsy: A comparatively large number of cases were diagnosed as epilepsy, amounting in all to 752. This number of cases afforded ample opportunity to observe the various manifestations of epilepsy, such as major seizures, *petit mal,* and epileptic equivalents. In addition to these well-known manifestations of epilepsy, the constitutional make-up of such patients formed an important part of their disability, and at times was of more significance than the actual seizures. In other words, the seizures themselves, in some cases occurring at rare intervals, might not have been disqualifying, but the neurotic or defective constitution that made up their background rendered these patients unfit as soldiers. The vast majority of these cases were highly neurotic—so much so, indeed, that at times it appeared that the disease should be interpreted as a severe degenerative neurosis, of which the seizure, while the most apparent symptom, was not the most important. Those observers who have favored this interpretation of many cases of epilepsy would see much in the clinical material of this hospital to support their contentions.

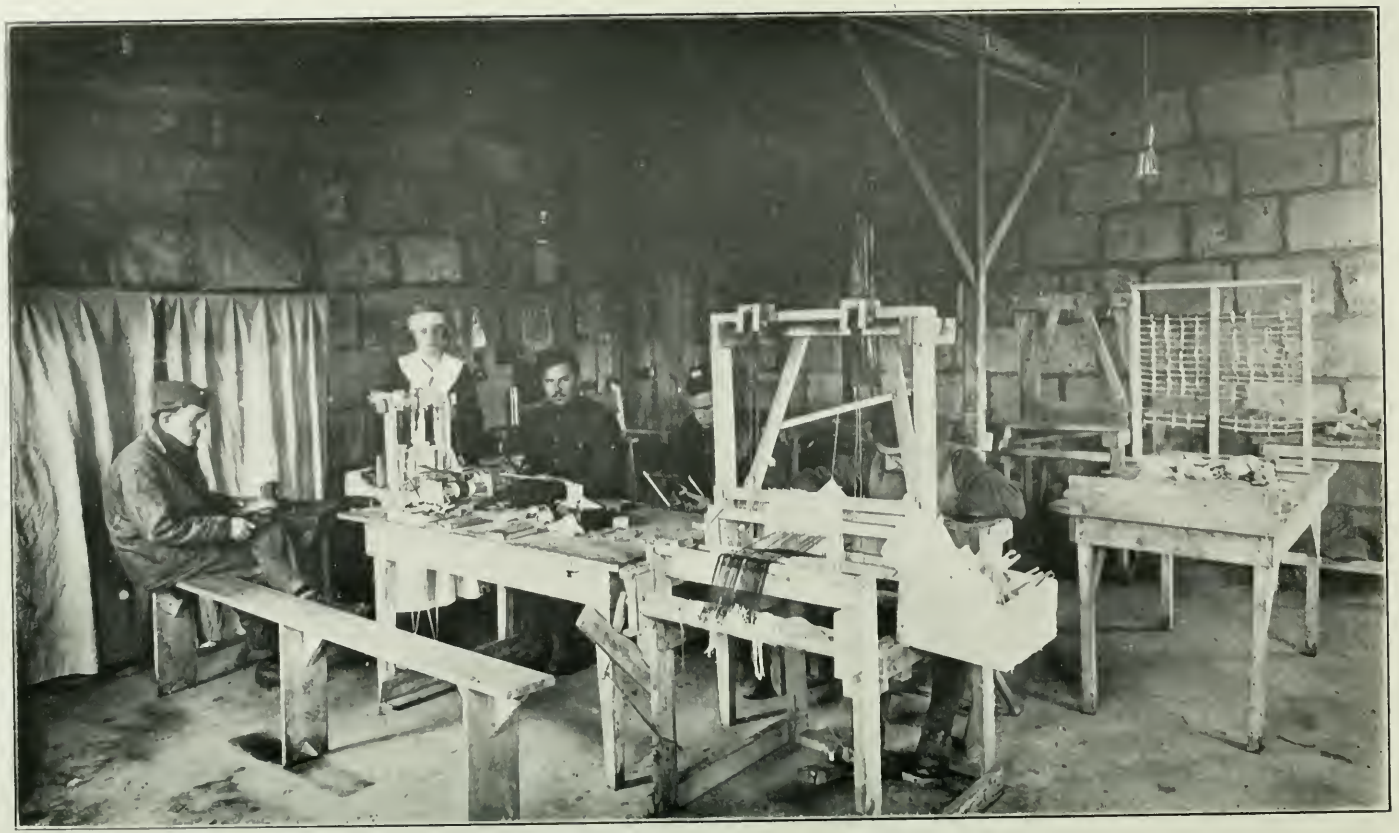
There were many border-line cases, which were thought to belong to this general group. Such cases frequently had slight mental defect and were sluggish in mental reactions. They presented numerous neurasthenic complaints of years'

standing. With this condition would occur minor attacks of loss of consciousness, with slight confusion and with occasional frank epileptic seizures. In these cases, the mental defect and the constitutional neurotic condition were of more importance than the actual attacks. Many cases came under observation who had had frank seizures at frequent intervals since childhood. These cases were readily recognized. Numerous types of epileptic equivalents were also encountered. Epilepsy was often associated with alcoholism. Where epileptic seizures occurred on an organic basis, the cases were classified as organic brain disease.

The question of so-called "hystero-epilepsy" arose at times, especially since this diagnosis occasionally appeared on the field card. No great difficulty was experienced in distinguishing the seizures of epilepsy from hysteria. A careful history and clinical observation were all that was necessary, as the hysterical seizures bore only a superficial resemblance to true epilepsy.

The Amnesias: These cases are discussed at this point because of the relationship of a number of them to epilepsy. A relatively large number of cases were encountered in which patients absented themselves from their organizations for periods varying from several days to several weeks. These patients maintained that they had no memory whatever of what had taken place. They either returned themselves or were picked up by the military police. Such instances occurred in both officers and men. A number of them were frank cases of epilepsy, the period of amnesia occurring either before or after a seizure or being an epileptic equivalent. Many other cases occurred after the excessive use of alcohol. After excluding both epileptic and alcoholic cases, however, many instances of amnesia of the type mentioned above remain to be explained. Such cases are not entirely clear. They were considered by many observers instances of hysterical amnesia, and this interpretation appears the most probable one, thus bringing such cases under the general group of psychoneuroses of the hysterical type. If this view is held, the amnesia could most readily be explained as a mechanism operating subconsciously, in which the individual escaped from a difficult or intolerable situation by wiping

General Workshop, Occupation Building, Base Hospital 214



Weaving Department, Occupation Building, Base Hospital 214

out from memory all circumstances associated with it. It is also probable that a number of such cases were conscious delinquencies, but the relative number of the latter type is thought to be comparatively small. All such cases raise medical-legal questions, as the matter of mental responsibility has to be determined.

Constitutional Psychopathic State: This group, which included 634 cases, consisted of patients who, while not suffering from frank mental disease, nevertheless were in a mental condition sufficiently abnormal to bring them into serious conflict with those about them. These cases did not differ materially from those seen in civil life, but presented such additional features as might be expected to develop under a military regime. Patients of this kind might make fair progress in civil life, where they could change their occupations and surroundings, but in the military service this was not possible, and they broke down nervously as a result. Indeed, they frequently suffered from temporary mental disorders. In this group were included some cases of alcoholism and drug addiction in whom such states were considered as symptoms in those constitutionally predisposed.

Mental Deficiency: Five hundred and twenty-four cases admitted were diagnosed as mental defectives. This number is not relatively large and it is probable that many defectives were eliminated before arrival in the A. E. F. The classification in respect to duty of these cases, particularly those with the lesser degrees of defect, was a question of considerable importance. It was considered that while defectives as a rule could not be used with combat troops, many of them would be serviceable in labor organizations. The disposition, therefore, was to reclassify such cases as were considered fit for duty in rear areas. The record of how these patients had conducted themselves in the military service was considered of greater importance than the testing of their mental age by scale. The emotional constitution of such patients was of considerable importance. A case with mild defect, if irritable and emotional, was often found unfit, while a case with a stable temperament, even with considerable defect, was considered fit for limited service.

In many instances physical defect was found to accompany

the mental defect, this physical defect varying in character and degree, at times being expressed merely by awkwardness in simple movements, at times making itself manifest in the gross, ungainly physical make-up of the mental defective. In still other cases appeared a constitutional physical defect of an ill-defined type. Such patients were stooped, had a narrow, ill-developed chest, and often a prominent abdomen. These cases often complained of numerous neurasthenic symptoms. They were related to constitutional neurasthenic types frequently seen in civil life, with mental deficiency added. It was soon found that it was unwise to return these cases to duty of any kind. They went on sick report or in hospital very frequently and they were more of a liablity than an asset.

Organic Nervous Diseases: This organization did not receive cases with lesions of the central or peripheral nervous system resulting from battle casualties, such cases being received by the surgical service of the Center. The other organic nervous cases, amounting in all to 143, were cared for at this hospital. No attempt can be made at this time to describe them in detail. Peripheral neuritis, occurring after diptheria, influenza, or other toxic conditions, was frequently encountered. Evidence of syphilis of the central nervous system was found in more cases than might have been expected, considering the average age of the patients. Several cases were diagnosed as brain tumor. A number of patients presented mental symptoms or epileptiform seizures subsequent to brain injury. Comparatively few cases of paresis or tabes were observed, although other manifestations of syphilis of the central nervous system were not infrequent.

Encephalitis of Undetermined Type:[1] During January and February, 1919, a number of organic cases of unusual interest were admitted to this hospital. The clinical features of these cases were first recognized by Major A. H. Ruggles, Chief of the Service at this time. They presented symptoms of such unusual interest that it is thought they should be discussed here, regardless of the fact that the clinical observations could not be completed. This report is, therefore, made tentatively, with the idea that it may be of use in confirming reports of other observers made elsewhere. The following

[1] Written before access was to be had to literature on this subject.

observations made by Major Ruggles are given as nearly as possible in conformity with his characterization of them. In all, there were about one dozen cases of this particular group.

The most striking feature of these cases was that they bore a rather close resemblance to paralysis agitans. They showed a stolid, masklike expression, a tremor suggestive of paralysis agitans, although differing somewhat from it, a shuffling gait, and a rigid posture, which suggested rigidity of the muscles of the neck and trunk. These cases also appeared dull mentally, but this was more in appearance, due to lack of expression, than in reality. There was no actual paralysis of the facial muscles, merely a lack of mobility and of expression. One patient could smile but very slightly, and could not laugh. Another had noticed, by looking in the mirror, that his expression had changed. The head and neck in these cases were held in a stiff and rigid position, but little if any true rigidity was found. The arms were held in semiflexure, both when the patient was walking and sitting. Here, too, however, there was not actual rigidity. The tremor was of a rather coarse type. The hand, as a rule, was held partly closed, but a pill-rolling motion was not observed. As a rule, both sides were involved, but one more than the other. The gait was shuffling and awkward; in fact, all movements were slowly and awkwardly performed. The gait suggested paralysis agitans, but was not entirely characteristic to that disease.

Physical signs indicating disease of the central nervous system, except those described above, were not marked. One case showed a remarkable lateral and rotary nystagmus with exceptionally wide excursions. Otherwise the eye symptoms were negative. There was no actual paralysis of the facial muscles. One case showed considerable tremor of the lips, which made it appear that the patient was about to weep; however, there was no emotional instability. The deep reflexes showed nothing remarkable except that in some instances the knee jerks were very active. The superficial reflexes were normal. There was no actual motor weakness, but motor functions were performed awkwardly. No abnormal sensory symptoms were apparent. The liver showed no evidence of disorder, and other physical findings were nega-

tive. Unfortunately, complete serological examinations were impossible. Spinal punctures were done in a few cases. No increase of cells or globulin was found, but punctures were done late in the disease and little definite could be inferred from these negative findings.

While these cases had a fairly close resemblance to one another—sufficient, it was thought, to place them in one group—they did not have that close resemblance throughout which is found in most cases of paralysis agitans. In some the tremor of the hands was the most marked symptom, in others the gait, and in others the lack of facial expression or the rigid posture. All, however, had some of the symptoms enumerated above to a certain extent.

Paralysis agitans is mentioned in connection with these cases for descriptive purposes only, not that they were thought to have any true relationship with that disease. The condition was thought to be encephalitis of unknown origin, the toxic agent showing a selective action, probably for the lenticular nucleus. No etiology could be established. Some cases had had a febrile reaction before admission and had been diagnosed as influenza. Others gave no history of any acute illness. Some of the cases had been confused and delirious at the outset of their illness, previous to their admission here. In favor of interpreting these cases as encephalitis of selective type is the fact that a number of other cases were admitted about this time in which the cranial nerve nuclei of the brain stem were involved. One such case showed first involvement of one seventh nerve. A few days later the other side involved. Both gradually improved and then a slight ptosis of both sides was observed. Later the sixth nerve on one side showed slight involvement, and there was also mental dullness during this period. All serological findings and physical findings were negative in this case. Other similar cases were observed during this time. Both French and British writers have recently described a condition which they term "lethargic encephalitis." This condition may have some relationship to the cases of encephalitis observed here. Cases seen here, however, were not particularly dull or lethargic, and although ptosis occurred, it was not as constant as observed by the French and British writers.

Red Cross Recreation Room for Enlisted Men, Base Hospital 214

Personnel of Officers, Base Hospital 214

Statistical Tables

TABLE I

Disposition of Patients Admitted from January 1, 1918. to February 28, 1919. Inclusive

Evacuated to United States	5,191
Returned to duty	267
Otherwise disposed of (transferred, etc.)	30
Census, February 28, 1919	605
Total	6,093

TABLE II

Diagnosis of Patients Admitted from January 1, 1918. to February 28, 1919, Inclusive

	Number	Per cent
Psychoses	1,916	31.45
Psychoneuroses	1,663	27.29
Epilepsy	752	12.34
Constitutional psychopathic states	634	10.41
Mental deficiency	527	8.65
Organic nervous diseases	148	2.43
Otherwise diagnosed	200	3.28
Awaiting disposition, February 28, 1919	253	4.15
Total	6,093	100.00

TABLE III

Monthly Admissions to Hospital and Evacuations to United States from January 1, 1918. to February 28, 1919, Inclusive

	Admitted	Evacuated to United States
January, 1918	369	*
February, 1918		*
March, 1918		*
April, 1918		*
May, 1918		*
June, 1918	256	*
July, 1918	405	217
August, 1918	588	455
September, 1918	887	839
October, 1918	658	695
November, 1918	809	801
December, 1918	412	650
January, 1919	885	697
February, 1919	824	721
Total	6,093	5,075‡

* Not recorded. ‡ Total recorded.

WHAT CAN BE DONE FOR THE MALADJUSTED?

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IT was as an attempt to work out a practical answer to the question asked in our title, by providing a place for the study of persons mentally and emotionally unadjusted, that in May, 1919, the Conference Center for Women and Girls was established for a period of eight months by the Social Morality Committee of the National Board of Young Women's Christian Associations. Supplementing their already well-organized departments for meeting physical needs, this undertaking, a piece of mental hygiene research, frankly concerned itself with cases that had been problems to themselves or to others, since opportunities for studying special industrial groups and functioning as vocational advisers—work that had been part of the original Conference Center plan—did not materialize.

Knowing the hypersensitive condition of many of these patients and their unwillingness to go to regular clinics, an effort was made at the beginning to avoid all suggestion of a hospital, and offices were taken in a business building, centrally located. All patients were seen by appointment and abundant time was allowed for a thorough consideration of each case. The number of interviews with or concerning patients varied from one to sixteen. The staff consisted of two physicians with psychiatric training, a psychologist, a social worker, and an office secretary.

The methods used were in no way unique. The aim was to make intensive, individual studies with the object of discovering the main factors responsible for the individual's failure to "make good." To this end psychiatric, psychometric, neurological, and physical examinations were employed, and considerable time was devoted to analysis of personality.

The work of the Conference Center was brought to the attention of its public largely through descriptive leaflets and personal interviews with representatives of leading social, industrial, and educational organizations, and it was interest-

ing to find a common enthusiastic reaction to the idea, with a ready appreciation of its value and practicability. The difficulty in dealing with the unadjusted person was generally recognized, and one heard repeatedly, in large business concerns, how unsatisfactory the ordinary hospital clinic had been found in the management of persons of this type, the rush of such a clinic precluding the careful, patient probing that in many cases must precede any radical reconstruction of the individual. It was interesting also to discover that in the few organizations which stated that no outside help was needed in handling difficult cases, employees who were inefficient or otherwise hard to deal with were discharged without any attempt at intelligent readjustment. Patients came to the Conference Center through the various channels suggested above as well as through private individuals and the various departments of the Young Women's Christian Association.

It is not easy to individualize the girls and women who came to us if we present them merely according to the usual psychiatric categories, as their different personalities were important factors in making them misfits, whether or not there was serious mental impairment. We were impressed by the low proportion in this selected group of frank psychoses (9.7 per cent) and feeblemindedness (15.2 per cent). These groups were the simplest to deal with. The mentally diseased patients were suitable for commitment, and while that was true for only about one-third of the mental defectives, it was possible to make the remainder more efficient and contented by means of suitable work and to safeguard them more competently by bringing their mental shortcoming to the attention of responsible people. Twenty-six and three-tenths per cent of our patients were psychoneurotics—many giving a history of childhood shadowed by neuropathic traits—who reacted to critical experiences by conversion hysterias, depression, obsessive thoughts, phobias, exaggerated inferiority feelings, or nervous tension. There were small groups diagnosed as border line in intelligence (6.9 per cent), as constitutional psychopathic inferiors (5.6 per cent), and as epileptics (2.8 per cent), while another small group (1.38 per cent) were undiagnosed.

The largest group (31.9 per cent) was made up of people who were normal as far as the absence of mental aberration or

defect was concerned, but who had a preponderance of personality traits that had interfered with adequate adjustment to life as a whole. Given any of the deviations from normality suggested above, a person finds all sorts of difficulties in an environment in which another, gifted with normal nervous and mental balance, lives efficiently and happily; and if in addition to mental handicaps there are surroundings that would strain the resources of a well-poised person, trouble is certain to ensue. It is true also that among those who cannot be considered mentally abnormal so far as their being victims of disease or defect is concerned, there are those who never make a complete adjustment to life—that is, they fall down in some particular field. Commonly this failure is in reference to their families or to certain members with whom they cannot get along, a situation that becomes more acute with advancing years, when failing elasticity is perhaps responsible for that intolerance which is such a factor in family friction. But instead of maladjustment in the home circle, it may appear in the wear and tear of business or in social relationships where tact is a *sine qua non*, or in purely personal struggles with misinterpreted emotions and misdirected energy, a condition which, though provocative of much inefficiency and mental torture, is too often unrecognized.

The type of maladjustment is determined largely, of course, by the individual concerned plus the situation in which he finds himself, but there is often a glaring discrepancy between the objective manifestation of faulty adaptive power—a matter of conduct which is the practical problem puzzling the referring agent—and the real problem, the essential causative factor, which is bound up so often with the emotional life and which is ordinarily overlooked in the management of the case. A certain group of patients, let us say, have a common starting point in that all are applying for work, but a study of each case reveals a great diversity among the causes that operate to make them placement problems; they are much more than prosaic job hunters.

It was rather startling, for instance, to find that the fundamental factor in the failure of an attractive, refined woman to settle efficiently in any industrial niche or to make desirable social contacts was a tremendous conflict centering about

incest experiences. Marked relief promptly followed a frank discussion of these experiences and may have averted suicide, which was threatened. Definite plans were subsequently outlined which extended from suitable work to recreation and ways of satisfying emotional needs. Less spectacular, but well worth attention is the case of a fifteen-year-old girl with unilateral choreiform movements, who gave a history of early neuropathic traits and of a severe attack of chorea at nine. Her lack of coördination was not noticed until shortly before our examination, when she drove a needle through a finger while receiving instruction in power-machine operating. This girl, of border-line intelligence, had eagerly anticipated earning a living as a great contrast to the grind of school. She was bitterly disappointed to find that she hated the two types of work chosen for her—in both of which she had failed—and being of a compliant nature, without much initiative, she looked forward to a black future of uncongenial work. She reacted to this with depression, irritability, and a recurrence of chorea. A rest period, with careful attention to diet, elimination, exercise, and recreation, brought prompt results, and later a job which combined outdoor and indoor work was successfully and happily handled.

Curiously enough, the psychogenic basis of a chronic asthmatic condition in a plucky, well-educated Irish woman had never received attention, although she had been given all sorts of extensive examinations and special tests in several of our best hospitals, where she had been under prolonged observation. Not only did the asthma incapacitate her for work, but it was driving her from one shelter to another as her frequent nocturnal attacks made her a nuisance to neighboring lodgers. She was interested in the new approach to her problem which the Conference Center offered and gave intelligent coöperation, with the result that the attacks, which had sometimes recurred several times in twenty-four hours, ceased entirely, and she recently reported that she had had none for over six months. She was no longer worn and apprehensive. Her general condition had improved because of sleep and better food which the ability to work steadily enabled her to procure.

Other cases worthy of brief mention are an epileptic forced

into unsuitable work which not only afforded no satisfaction, but was a constant worry; a psychopathic personality, of paranoid trend and with physical handicaps, who demanded definite social and industrial conditions as a compensation for having been born and having to live in a most inconsiderate world; a high-grade moron, depressed and discouraged because nagged by her family to continue working as a stenographer although unable to hold positions; a psychoneurotic, with a marked inferiority complex and some schizophrenic symptoms, who failed to realize that she was not meeting efficiently the increasing demands of an enlarging business until forced to resign, an experience never accepted and consequently a hindrance to adaptations in new positions. Such diversity of causative factors and the consequent necessity for individualized recommendations as the above patients show indicate the need of expert advice for difficult cases if employment exchanges are to realize their greatest usefulness to employer and employee.

Among those whose problems had a distinctly personal bearing was a woman in the late twenties whose lack of adjustment to a broken engagement was demonstrated objectively by depression, self-reproach, seclusiveness, and lack of interest in her work. She was an unselfish, conscientious type, sensitive and proud, who had been educated to think that marriage was the only goal in life; her mother had encouraged her not to become too much interested in business lest she should thereby seem less attractive as a wife. Her whole family rejoiced over her engagement and as wholeheartedly lamented its termination, which the man's waning interest and finally open neglect made inevitable. The question of emancipation and sublimation was discussed simply, but thoroughly, and she was willing to follow definite suggestions regarding change of position, cultivation of new sources of satisfaction, wider interests, etc. Her depression cleared as her self-respect was restored, and adjustment was facilitated by the substitution of a new life plan for morbid brooding over the past and unsettling fantasies of what might be if a reconciliation with her lover were effected.

Another patient, a psychoneurotic over forty, with a marked inferiority feeling, reacted periodically to a tyran-

nical old mother—for whom, both intellectually and temperamentally, she was no match—by converting the effect of various disturbing complexes into physical complaints. Although the patient was not antagonized by a frank presentation of her mechanism, it must be said that there was no manifest change in her. This, perhaps, was not strange, as she was a timid soul who knew from experience that her methods brought practical results, such as sympathy and consideration, which her egotism craved, as well as such tangible things as extra spending money, the occasional services of a trained nurse or masseuse, and new clothes, which were welcome variations in a monotonous existence even if they were nothing more satisfactory than a promptly discarded collection of orthopedic shoes. Although no brilliant results were obtained in this patient, who was seen but a few times, at least a new point of view was offered which may influence future behavior.

We found among the patients who were referred to us as conduct problems that something could be done for a schoolgirl whose stealing seemed related to conflicts centering about an unhappy home situation in which a drunken stepfather figured. We found, after carefully questioning an adolescent runaway, that recent accidental confirmation of a long felt suspicion that she was adopted had resulted in recklessness and general revolt against the authority of her foster parents and a restless longing to find her own people. It was possible to bring about a better attitude toward her foster parents, of whom she was really fond and to whom she expressed a desire to make good if allowed to return.

In the group referred as suspected mental cases was a girl of twenty who was regarded as an early schizophrenic. She was a student who complained that her work was going badly because her poor concentration made studying difficult and at times impossible. In her efforts to make up one subject she neglected others. She blamed herself extravagantly for disappointing her teachers, was nervous, irritable, and depressed. During the first interview she displayed such an exaggeratedly prudish attitude that the cause therefore was immediately sought and as promptly discovered. In answer to questions, the patient, unwillingly at first, but later with relief,

told of sex experiences initiated at three years by a fourteen-year-old boy and continued for eleven years with four older brothers; also of auto-erotic habits carried on frequently during the same period, never entirely abandoned, and always accompanied by much undisguised sexual rumination. Infrequent homosexual practices indulged in during early adolescence had been given up, but there remained much daydreaming colored by homosexual fancies. At the age of fifteen, after reading a certain sex hygiene book with an uplifting title, a conflict between her desires and her ideals was set up which strengthened with the years. She compensated for her sense of guilt by inveighing against all males—"those creatures"—by talking much of purity, cultivating the excessively prudish attitude above referred to, and dwelling on her appreciation of beauty and spirituality. When first seen, she liked to think that she had gained a satisfactory mastery of her "passions," but it was evident to the examiner that her mind was so sex saturated that other interests were secondary. She was encouraged to talk freely, to ask any questions she chose, to make notes of her dreams, and to write letters in which she discussed matters taken up in interviews, this affording a means of gauging her reaction to the attempted reconstruction of her sex life on a healthy basis. It was interesting to see her attitude change from a frank resentment at having "forced" on her attention things which she had "successfully subordinated to the most minor rank" to as frank an acknowledgment of obsessing sex imagery with great temptation, sometimes yielded to, to indulge in her old habits, and finally to a conception of sex life which did not conflict with the broader, healthier viewpoint she had gained. She became more cheerful and self-reliant, her school work improved as her daydreaming diminished, her relations with her companions of both sexes became more natural, and she expressed a more tolerant attitude toward her family, which must have made her much pleasanter to live with. Her make-up was such that the development of a psychosis seems inevitable had not free discussion brought relief from obsessive sex thoughts and had she not been encouraged to increase contacts with reality and been helped to do so by being held strictly to a practical program.

Another girl of about the same age was sent for examination because she complained of depression and emotional instability. Her mother, described as "never happy and very quiet," had died when the patient was eight months old as the result of a fever following childbirth, which "upset her mind." The father, a delicate man, an occasional writer of poetry, who has never made a good living for his family, married again when the patient was a year and a half. Although she has never been unkindly treated, there has been no affection or congeniality between the stepmother and the patient, whose inferiority feeling has been fostered by a total absence of encouragement plus the fact that since early childhood frequent comparisons have been drawn between herself and a half brother, always to her disadvantage. As a child, she generally felt gloomy and depressed. She was quiet, timid, afraid of the dark, easily hurt, unaggressive in her relations with other children.

When about seven, she was terrorized when preparations were made in the small Russian town where she lived to resist a threatened massacre of the Jews. In her fourteenth year she journeyed alone to America to join her father, who had come a year before hoping to better his condition. Shortly afterward, the patient's stepmother and half brother came and all have lived together ever since. The girl had received some private instruction in Russia and graduated in elementary work here after one year in a special class in day school and two years in night school. She became a factory operator as soon as she was eligible and has worked steadily and efficiently, but without interest or pleasure—"It is just work."

When she was about sixteen, she suddenly realized that she was much in love with a married man distantly related to her, employed in the same factory. She had no conscious desire to alienate this man's affection from his wife and reproached herself for her feeling, which she sought to hide and of which she became painfully self-conscious. Her daydreams were filled with sex imagery and there was then revived a half-forgotten experience which she had had when she was thirteen, when she inadvertently witnessed an act of sexual intercourse. The curiosity which she had previously had on this subject was thus gratified, but she reacted with

deep disgust and found the memory an obsessive thing until the many new impressions gained from emigration were superimposed. However, after the "consciousness of sex" caused by her love affair appeared, this earlier experience was again vividly recalled and formed an important part of her fantasies, except that she and the man with whom she was infatuated were substituted for the other pair. It still appeared to her as a disgusting performance, something so dreadful as to make her think she could never marry.

The self-consciousness which made painful any casual contact with the man with whom she was in love gradually extended until she was hampered in associating naturally with any man. She avoided all social contacts with the opposite sex and even dreaded meeting them on a business basis, although she was able to wait on customers in her father's store without showing painful enbarrassment. She became indecisive and had morbid doubts about trivial things. She suffered from excessive blushing and had a pronounced feeling of insufficiency. She was depressed, had suicidal thoughts, and was emotionally unstable. Her dreams dealt with pursuit by men from whom she made ineffectual efforts to escape, of men breaking into the house, and of other more definitely erotic manifestations. As repression in her case had always been marked, almost immediate relief from tension was gained from the frank statement of her difficulties. She was very coöperative and intelligent, so that with a little help she readily traced the connection from effect back to cause. Although she did not immediately get over her morbid habits of thought, she became less depressed and gradually gained a new and more mature point of view than she had formerly held regarding sex matters. Efforts were made to increase her interests, social, esthetic, altruistic, and according to the last report she was greatly improved in every way.

Although this brief paper has treated so largely of individual patients studied at the Conference Center, mention should be made of group testing, under the direction of the psychologist of the staff, of children from the sixth to the eighth grades, in connection with the work of the Vocational Guidance Committee of the public schools. Seven hundred and one children were examined by means of "Thorndike III." a

modification of the army test known as examination Alpha, and the army Beta test. For the small number of cases where the group test showed either an extremely high or an extremely low record, or when there was discrepancy between the results of the two group methods used, the group tests were supplemented by individual examinations with the Stanford-Binet. In submitting reports of the examinations to those interested in having the tests made, the point was emphasized that these tests were valuable in supplementing other sources of information—such as the judgment of teachers who have known the children for some time—since they were independent of any personal equation, but that they were measurements of intelligence only, not of personality traits or of special abilities or disabilities. The need for such work is, we believe, becoming more and more recognized by vocational counselors, and cordial appreciation has been expressed for the small contribution which the Conference Center was able to make.

Obviously, after only an eight months' experiment, the results of the Conference Center cannot be presented as conclusive, but they are unquestionably suggestive. We know from the testimony of patients themselves, as well as from people interested in them, that many have gained a greater self-knowledge which has aided them materially in meeting problems involving family and social relationships, industrial demands, sex, and other emotional conflicts. As aids in coping with such problems, following the initial analysis of the situation, practical recommendations have been made regarding remediable physical handicaps, personal hygiene, recreation, cultivation of hobbies, and the desirability of viewing work as a source of satisfaction and interest rather than as a drab means to the necessary end of earning a living.

There is no doubt that the medical approach is the one through which the patient most easily gives his confidence and which consequently brings the best results, while the reassurances or recommendations of a physician carry more weight than do those of a layman. The individual whose maladjustment may be due to matters which are of relatively slight importance, but which have become magnified and distorted through morbid brooding, finds it more natural to

speak of intensely personal affairs to the physician or priest than to the lay person, even though the latter be very sympathetic and intelligent.

Psychiatry has a wide social application, which fortunately is being recognized more and more both by the psychiatrist himself and by social organizations, not only along strictly preventive lines, but also in dealing intelligently with the problems of people who, while not incapacitated for work, never realize their possibilities in efficiency and often go through life heavily handicapped by their misinterpreted selves. A conviction has been reached that work such as that which the Conference Center has attempted has a definite practical value, but in order to be of the greatest usefulness, it is believed that it should function in connection with a well coördinated organization that is adequately equipped for investigation and follow-up work. The psychiatrist needs help from the investigator to check up statements made by the patient, and after he has carefully studied the case, his recommendations are often futile unless an intelligent worker helps to carry them out. In dealing with these difficult adjustment cases, good teamwork is absolutely essential and can be obtained best in one organization whose policies and aims are unified.

Additional suggestions along definite practical, preventive lines have gradually accumulated during study of the individual patients and are as follows: (1) need for early detection and wise handling of such hampering tendencies as fear, suspicion, discontent, seclusiveness, lack of self-control, dependence (on people, on the opinions of others, etc.), morbid or unproductive daydreaming, a tendency to the dispersion of energy and interest, inferiority feeling, depression, and secretiveness; (2) need for rapport between children and parents and teachers; (3) need for simple, straightforward, but biologically sound sex instruction to children and adolescents; (4) need for employment of physicians with psychiatric training in connection with schools, vocational departments, employment bureaus, and other social agencies which necessarily deal with problem cases; (5) need for intelligent vocational advice based on thorough individual study, since work as a source of satisfaction is too little appreciated; this applies

equally to those who have never realized their possibilities and to those who struggle with work which is beyond them; (6) need for meeting adequately and individually the loneliless problem which plays such a rôle in city life.

The final idea which we would stress is that, instead of accepting the fact that a person is difficult, an intelligent effort should be made to get at the causes, to seek to understand instead of condemning, and to employ such remedial measures as seem best adapted to the individual case.

AUGUST HOCH

Resolution Adopted by the National Committee for Mental Hygiene

SINCE our last annual meeting, there has passed from earth one of the members most active in the organization and early work of this society. Dr. August Hoch was a truly great clinician in the field of mental medicine. Although he was deeply absorbed in studies which have thrown light upon some complex problems in psychopathology, the practical application, in treatment and prevention, of truths learned in the ward and laboratory was always uppermost in his mind. He was one of the first to see that the knowledge of mental mechanisms revealed by the study of disease would have quite as important results in dealing with controllable causes of mental disorders as in correctly interpreting symptoms. With no illusions as to the ease with which such causes might be attacked, he nevertheless insisted that clinical psychiatry and mental hygiene were twin arts and should be advanced side by side. Long before the literature of mental hygiene had reached its present size—indeed when all important contributions to the subject could be counted on the fingers of both hands—Dr. Hoch presented, under the title of *The Manageable Causes of Insanity*,[1] a very thoughtful consideration of the light thrown by case histories of grave mental disorders upon causes that might be dealt with successfully at an earlier period. In his *Social Side of Psychiatry*,[2] published in 1910, he directed attention to the wide usefulness of psychiatrical knowledge in efforts to cope with many of the evils that threaten society. He lived to see not a few of the suggestions made in this paper put into effect with striking results.

1 Published in the *State Hospitals Bulletin*, Vol. II (new series), 358-83, September, 1909.

2 Read at the Eleventh New York State Conference of Charities and Correction, Rochester, New York, November 15-17, 1910.

Indirectly, by thus calling attention to the contributions that clinical psychiatry had to make to preventive medicine, Dr. Hoch rendered important services to the cause of mental hygiene, but in addition he took a very active part in the affairs of the National Committee, of which he was one of the charter members. He served as a member of the executive committee from 1911 to 1915 and, from 1915 until he was obliged to go to California on account of failing health in 1917, he served as its chairman. During that time no member of the committee took a keener interest in the work and in the solution of the knotty problems that came up during the first few years. His voice was always for sincere, earnest, well-grounded work, regardless of whether public appreciation of it came early, late, or not at all. Pressed as he was by his duties as Director of the New York State Psychiatric Institute and his clinical researches, he attended meetings with unfailing regularity and was always ready to devote hours of his time to conferences, the examination of reports, and other duties. It would be very difficult indeed to speak adequately of the value of his judgment and the influence of his breadth of view in shaping policies that have since been shown to be sound. His delightful personality made such meetings and conferences occasions to look forward to.

It seems altogether fitting that at this meeting some formal expression be made of the debt that the National Committee for Mental Hygiene owes to Dr. Hoch, and so the following resolution is moved for adoption:

Resolved, that the members of the National Committee for Mental Hygiene express to the family of Dr. August Hoch sincere sympathy in their personal loss and profound appreciation of Dr. Hoch's services to the advancement of mental hygiene, not only as a teacher and psychiatrist, but as a trusted leader in the organized work of this agency.

ABSTRACTS

THE NEUROTIC GIRL. By Jessie Taft, Ph.D. *Modern Medicine,* 2:162-70, February, 1920.

After deploring the tendency often to be observed, not only in lay persons, but also in social workers and physicians, to assume a pitying or contemptuous attitude toward the malajusted individual, Dr. Taft discusses the significance of the presence or absence of constitutional basis. "This question," she says, "must be ignored inasmuch as for our purposes it is immaterial. If there is a constitutional tendency toward instability, the altering of behavior will undoubtedly be more difficult. There is an ever-present, unchangeable handicap, but improved adjustment on the basis of just this handicap is surely possible. For instance, a feebleminded child has a constitutional defect, but, given that defect, it is still possible to find a level on which he can make a fairly good adjustment. His behavior is not necessarily bad because his intellect is defective. Because the neurotic individual has an oversensitive, unstable nervous make-up does not mean that he cannot learn to use it to the best advantage.

"On the other hand, we must all admit that the line between the neurotic constitution and the normal constitution whose reactions have been developed along an unhealthy line by the peculiar combination of internal and external circumstances is an extremely hard one to define. It is far safer to ignore as much as possible the presence or absence of the organic basis and work on the concrete problems presented in the bad contacts which any given individual is making with reality. Now, see what has happened: the term neurotic has lost all significance because our standard of measurement—that is, adequate or efficient social adaptation—applies to everybody, normal or abnormal. We need no longer worry about labels or diagnoses; the procedure is the same. The only question is: here is a person who is not making efficient contacts; how can he come to realize the cause of his difficulty? Or, if he is too young for that, how can we remove the causes so that he will naturally respond in a more socially desirable way? In other words, I find myself unable to differentiate between the problems that arise in the life of the so-called neurotic girl and the problems that arise in the life of every girl. In consequence I am helpless to describe an environment and educational system which is good for one and not for the other. As I see it, the normal girl is always somewhat neurotic and the neurotic girl is always somewhat normal; at least, her mental machinery is at bottom of the same make, however badly she may be using it. Con-

sequently, an environment and educational method which is peculiarly bad for the neurotic girl cannot be very good for the normal, although the latter may have a better chance of surviving.

"As I see it, then, the question I have really been asked to discuss is: in what way can education and environment be made to solve the problems of mental health that are so acutely and conspicuously present in the life of the so-called neurotic girl, but are common to all, girls and boys alike."

The whole problem resolves itself into the possible conscious control of mental and social life, which will make mental health and social adaptation as responsive to human desire and needs as it promises to make physical health. This problem cannot be relegated to a single group, but belongs to society as a whole. At present, a small group of modern psychiatrists is throwing almost the only available light on the subject. The psychologists in their laboratories have, for the most part, been occupied with artificial problems or purely intellectual situations. Certain groups of psychiatrists, on the other hand, have been observing actual changes produced or not produced in the concrete behavior of actual human material, and have thereby made revolutionary contributions to a new dynamic psychology based on modern biology. "It is to this new psychology that we have to look for the solution of society's great mental hygiene problem. There is no other available. The academic psychology makes no difference to life and the older psychiatry holds before us only the finality of heredity and the unalterable nervous structure." However, it would be impossible to throw the whole burden of mental health upon these chosen few who understand the new psychology. Psychiatrists, psychologists, and mental clinics would be hopelessly swamped. The general medical profession, social agencies, institutions, and other professional groups must coöperate in dealing with these problems from a psychological standpoint before they become so acute as to require a psychiatrist.

"For the purpose of this paper, the neurotic girl is the girl who resists emotional maturity because every stage of growth demands additional effort to which she is unequal." Home conditions, family life, a real inferiority that she is unable to overcome, may all lead to infantile and childish methods of obtaining satisfaction. The neurotic girl is to be found everywhere, irrespective of class or condition. The ultimate solution of the problem lies in educating the parents in the understanding and use of the new psychology. Since the war, a new kind of social worker, known as the psychiatric social worker, has appeared. "Her place is in the parole department of a hospital for the insane, in the parole or out-patient department of a psychopathic hospital, and in the psychiatric clinic. She brings to this new field

a previously acquired technic in family case work . . . a method of assisting families and individuals in them to make more satisfactory social adjustments." She tries to change behavior through improving the physical, economic, and social conditions in which the individual has been living, and accomplishes her results, as far as possible, through the aroused interest, intelligence, and initiative of the maladjusted individual himself. Her chief value is seen in those centers where the psychiatrist handles large numbers of cases without being able to give to the individual the attention required. She takes over from the psychiatrist the interpretation of the case, combines it with her knowledge of social conditions, goes into the details of the girl's life, and so is often able to remove the worst obstructions and help her to understand the reasons for her difficulties.

Another result of the aroused interest in social psychiatry and the demand for case workers with a knowledge of psychology and mental disease has been the establishment of courses in social psychiatry in many of the large Eastern cities. Dr. Taft comments upon a number of these classes and training schools.

But the social worker's field is limited. She comes in contact with comparatively few families, for the most part those where poverty is a factor. The needs of the average middle class and of the wealthy are equally pressing. "With a single exception, it seems to me the physician in general practice is the most important and as yet comparatively the least used agent for conscious mental health in our social structure. Particularly is this true of the woman physician, who is peculiarly fitted by inclination, interest, and the character of her patients for dealing with the problem of the neurotic girl. . . . Because the neurotic girl always develops physical symptoms as critical situations are forced upon her, whatever her station in life, she is practically sure to find her way to the general practitioner, and, as there is often a question of some disorder involving the sex organs, the physician is frequently a woman." The fact that the physician is in the confidence of the family often enables her to educate the family in the treatment of the girl and in the correction of the conditions responsible for her state, and gives her an opportunity to teach both girl and parents how the weak spot may be strengthened by facing it and slowly training it into efficiency, or how compensation may be made for it by a simple acceptance of the defect and a strengthening along other lines.

"On the sex side of the resistance to maturity the woman physician undoubtedly can be of the greatest assistance in reconciling the neurotic girl to the idea of normal sexual development. I think we often make grave mistakes in our programs for sex education by confusing knowledge of the facts of sex with emotional adjustment to those

facts in real life. We assume that the home, the friends, social opinion, and custom as the girl knows them have toward these facts the same wholesome, sensible feeling that we who are giving the instruction have, or ought to have. We presuppose that the girl's social environment has done nothing but repress the facts, and all that is to be done is to see that she gets them simply and scientifically. The thing we overlook is that the environment has bred in the girl an emotional attitude toward the very facts it has concealed and that attitude is usually made up of horror, curiosity, disgust, and fear. To the girl with such an innate attitude, knowledge of the facts may only increase the horror and curiosity, and produce an added emotional resistance. . . . Teaching sex by the mass method is a doubtful procedure if it cannot be followed up by the most careful individual help to the girl who has a problem. The safest way is to give the essentials of sex, with no special emphasis, in the natural place in school, either in biology or physiology. Then the case-work method must be used to meet the emotional conflicts, and nine times out of ten the woman physician will be the one who has the opportunity to help make the adjustment."

Another agency for the salvation of the neurotic girl is the school. "It is the most important and the most unprepared for the task of any except the home." The school as it is to-day usually deepens the neurotic tendencies of children showing such defects. The neurotic child is driven into many forms of delinquency; anarchy and invalidism, or its emotional reactions, are hardened into permanent moods. The school is, of course, unconscious of this influence. In the large cities of the country, where the enormous school population tends to submerge the machinery, the necessary ironclad system tends to kill any enlightenment principals or teachers may possess.

"If our public schools really educated, if they understood that education involves a training of the instinctive and emotional life as well as of the intellect, if they saw that they cannot even develop intellect as long as they ignore desire, we should have an agency for adjusting the neurotic girl and boy second only to the home in its power. There is proof for this statement. Enlightment is coming into education in spots. There are visiting teachers who work on the problem children in a school and get wonderful results. There are experimental schools whose methods are based on an understanding of the new psychology as it applies to educational theory. These schools are able to deal with the able, but neurotic child who cannot get along in the public school. Those of us who work with difficult children are defeated constantly not so much by the impossibility of the cases as by the impossibility of finding any public school that understands or has time to act on its understanding."

Dr. Taft relates some of her experiences in "straightening out" children the public school cannot handle. She concludes her article as follows:

"Many such children, who make up our incorrigibles, could be saved by the public school. It would mean teachers with a new psychology; it would mean more time to each individual child; it would mean small classes, more buildings, more teachers, and a great deal more money; but in the long run it would save money as well as children. The attention has to be given to neurotic children some time. They make us pay for refusing it earlier by exacting it later, in our many institutions, in ruined homes, in wasted lives and squandered energy.

"There is surely no program for social betterment which is so worth a lifetime of effort and interest on the part of the medical profession as a mental-hygiene program which has for its goal the use of the public school system to develop the child, neurotic or normal, into the best adjusted human being that he is capable of becoming."

Applications of Psychiatry to Industrial Hygiene. By Stanley Cobb, M.D. *The Journal of Industrial Hygiene,* 1:343-47, November, 1919.

The widespread social unrest and industrial discontent in the world to-day have become problems of such immediate importance that they are attracting the attention of experts in all fields of thought. Not only is more intelligence being brought to bear upon them than ever before, but it is a hopeful sign that from whatever point of view they are approached "there is shown a feeling of broad humanitarianism, a desire to understand each member of the industrial system as an individual, and a reaction against the old system of exploiting labor to produce wealth.

"It is in just this field of understanding the individual worker and his reaction that psychiatry is of use. Carleton Parker even goes so far as to say that 'modern labor unrest has a basis more psychopathological than psychological, and it seems accurate to describe modern industrialism as mentally insanitary.'"

There are a number of reasons for this mentally insanitary condition of modern industry. Marot, in her *Creative Impulse in Industry,* has brought out some of them, showing how the use of machinery has reduced the worker to a mere automaton, with no joy in his work and no motive for it but the pay envelope. "But this is only one of many difficulties. Among the economists, Parker has been the pioneer and has most vigorously preached the necessity of understanding human behavior, and especially industrial behavior, from an individual standpoint. . . . When human motives are isolated, de-

scribed, and compared, such phenomena as business confidence, the release of work energy, the decay of workmanship, decline in the thrift habit, and labor unrest may be analyzed with some intelligence. But the careless *a priori* deductions touching human nature which still dominate our orthodox texts must be discarded. As a substitute for the orthodox and vague concept of human nature, Parker gives a list of 'some sixteen instinct unit characters which are present under the laborer's blouse and insistently demand the same gratification that is, with painful care, planned for the college student.' ''

The thwarting of these instincts, Parker shows in his analysis of the I. W. W., ''brings about a state of mind that amounts to an industrial psychosis.'' Shortening hours and increasing pay will not in themselves solve the problem of industrial unrest and discontent; what is needed is education in constructive ways of satisfying the great fundamental human instincts. Other economists, such as Taussig, Fisher, Tead, and Veblen, are sounding the same note—that the present unrest is really a pathological condition, due to the unconscious hunger of the great mass of workers for a life more psychologically free and satisfying than modern industrialism provides. ''So it appears that the economists are becoming psychiatrists and are showing the way to the physician. If the physician is to take his rightful place in developing the mental hygiene of industry, he must forget orthodox psychiatry (as the economist seems to be forgetting cut-and-dried political economy) and interest himself in a dynamic, individual psychology which recognizes the essentials of human nature and at last begins to analyze for us the elements of which human nature really consists, looking on each case as a human experiment in reaction to environment.''

The case of a fur worker in a Boston department store is cited to show how an illness that represents a reaction to an intolerable situation can be more effectually cured by a little assistance based upon an intelligent understanding of the personal problems involved than by any amount of treatment of the mere general symptoms.

The same thing is true of people whose reaction takes the form, not of actual illness, but of inefficiency, discontent, a desire to wander, an inability to stick to a job. ''Before these people have left their work or have been fired for inefficiency, they should be interviewed by some one competent to understand them and their probable troubles. At such times advice from a physician, the loan of some money, a visit to a sick child or wife, or any of the thousand possible personal and individual aids, might save the worker from becoming soured, keep him from joining the ranks of the discontented, and prevent the development of a litigant and paranoid personality.

Employment managers are beginning to recognize these facts and are using various methods to alleviate the troubles: one firm employs a lawyer especially to watch the loan sharks and help out employees in financial difficulty. Others keep man-record charts and watch carefully the workers' efficiency. Too often this is merely for purposes of sizing up the employee, but one firm has shown that frequently a drop in a man's efficiency can be traced to personal difficulties of a nature that can be helped.

"So we get back to the necessity of understanding human nature and of giving to the fundamental human cravings an outlet. The instinct of self-preservation is partially satisfied with the pay envelope; welfare work helps to make possible satisfaction of the instinct of home-building; but with our present industrial system it is harder to see how the cravings for self-assertion, creation, excitement, and the like can be met. The atmosphere created by the division of labor and scientific management is repressive to all these instincts—the man may develop a feeling of inferiority, and unless given some outlet he will become discontented and get satisfaction through striking, drinking or other abnormal sublimation."

The success of psychological tests in the army has awakened a good deal of interest in the possibility of applying mental tests to applicants for industrial positions, and good results have already been reported from the use of such tests in choosing certain types of workers. In the present state of our knowledge, however, perhaps the best practical suggestion is that factory training departments be installed in all plants as testing places for applicants for factory work, thus providing for the elimination of incompetent candidates and consequently keeping the morale of the departments at a higher level and decreasing labor turnover.

The psychological element in fatigue brings it, too, within the field of the psychiatrists. In this connection, Spaeth's use of the term "industrial psychoneurosis" is criticized. He suggests that it be used to designate "the accumulating fatigue of the over-driven worker," but overwork in itself is never the fundamental cause of a neurosis or a psychosis. "These disorders are fundamentally emotional breakdowns due to lack of satisfaction with life, so the theory that the etiology is 'gradually accumulating fatigue' is untenable. The symptoms may simulate fatigue, but neuro-muscular fatigue is cured by simple rest, and these conditions are not. 'Industrial psychoneuroses' are simply neuroses with an occupational coloring due to the work in which the individual happens to be engaged.

"The mechanism of such a neurosis is typically something like this: An individual is in an intolerable situation which he is constitutionally

unable to dominate; the reaction of a neurosis sets in with depression of spirits, irritability, preoccupation, self-pity, etc., but a conventional cause for the decreased efficiency must be found to rationalize the situation, so the individual calls it overwork. Obviously, with this idea of overwork in mind, the symptom usually acquired is fatigue or asthenia, but frequently symptoms more closely associated with the work are developed, such as paralysis of parts of the body necessary for work, muscular pains making work impossible, tremors, or even epileptiform seizures. The case quoted above is an example of emotional breakdown from personal causes taking on an occupational symptomatology. The work may have determined the form of the symptoms, but there is no evidence that it had much to do with the development of the trouble. Work may of course be an etiological factor, but not through so simple a mechanism as accumulated fatigue. Work that represses emotional cravings often brings out neuroses, just as satisfactory work is the greatest curative agent we have for these conditions. Let us no longer fool ourselves into thinking that overwork, *per se*, is the cause of mental breakdown."

The problems of industrial psychology may be summarized as follows:

"A. Prophylaxis of mental breakdowns by adapting the worker to his environment, and eliminating causes of discontent.

"B. Treating psychiatric cases when they arise in a rational way according to the facts of each case, and considering as psychiatric phenomena many forms of behavior that until recently have been given unsympathetic names, e. g., 'the groucher,' 'the kicker,' 'the trouble maker,' and 'the hobo.'

"As conditions are at present, a reasonable application of psychiatry to industry would seem to be the following:

"1. Physical examination of all applicants for work.

"2. Mental examination by (a) a period of training and observation, or (b) through mental tests.

"3. Keeping in personal touch with employees' individual problems by means of (a) good foremen, (b) a system for watching individual efficiency, or (c) a sympathetic staff with a psychiatric point of view in the employment management office, thus salvaging the men who might otherwise be fired.

"4. Training the industrial physician to a knowledge of how human nature is constituted, not in conventional terms, but in the light of a dynamic and living psychology that considers the behavior of human beings in terms of instinctive sources of energy, integrated into motives, these motives needing outlet through energy transformation into satisfactory activity."

MALINGERING. By Ex-Major Joseph Catton, Medical Corps, U. S. A. *Military Surgeon*, 45: 706-717, December, 1919.

Malingering is defined as, "When imitation begins to have an element of deceit it becomes simulation; when simulation regards health it becomes malingering. Likewise lying, deceit, fraud, and feigning, when they are applied to matters of disease or disability, constitute malingering. Malingering includes fraud as regards existence, etiology, symptomatology, and severity of a disease or disability."

An extensive review is made of the literature on the subject both in this country and abroad, the consensus of opinion being that genuine malingering is rare and that the greatest error is probably made in failing to recognize and properly evaluate nervous and mental symptoms. The personal observations of the writer were made as Chief of the Medical Services of Hospital No. 64, U. S., Convalescent Hospital No. 2, and Base Hospital No. 99, A. E. F.

Suggestions for differential diagnosis are made: first, that organic disease be eliminated, differentiating between organic disease and malingering and functional disease together; second, differential between functional disease, particularly hysteria, and malingering. Having arrived at the opinion that the case is one of malingering, the diagnosis is not to be made, however, except on the confession of the patient or unless the basis of the conclusion can be objectively demonstrated. The patient at this point is to be referred to the psychiatrist. "The non-expert opinions of medical officers, although based on thorough and repeated examinations, cannot be final as regards the basic psychology in a given case and the responsibility of a given individual for his acts. Therefore the suspected malingerer must always be given a psychiatric examination. The result of the latter will demonstrate whether he is one of the number of supposedly mentally normal individuals who have simulated or exaggerated disease because they are underfed, overworked, or lack education, especially moral education as regards responsibility and the like; or whether he has a psychoneurosis, especially hysteria, traumatic neurosis, or pathomania; psychosis, *e. g.* traumatic psychosis; inebriety, especially alcoholism or morphinism; mental deficiency, especially including morons and border-line conditions; or constitutional psychopathy, especially pathological lying or criminalism."

The writer's conclusions are that "while out-and-out malingering is exceedingly rare, the minor forms are rather widespread in occurrence and should be looked for carefully in order that fraud may not be a drain on the efficiency of the military organization or upon the funds to be expended for hospitalization or upon the compensation to be distributed as pensions or in consequence of the War Risk In-

surance Act; secondly, in order that the patient himself may be benefitted by such treatment as is indicated for the mental disturbance that may be found at the bottom of his complaints."

SYPHILIS IN RAILROAD EMPLOYEES: A CLINICAL STUDY OF AN OCCUPATIONAL GROUP. By John H. Stokes and Helen E. Brehmer. *The Journal of Industrial Hygiene,* 1:419-27, January, 1920.

This study was undertaken as the result of an impression on the part of the writers "that syphilis is an exceptionally common disease among railroad employees and that it constitutes a grave and unrecognized menace to their personal welfare and industrial efficiency and to the safety of the traveling public. In order to ascertain the statistical basis for this impression, a review of 3,000 unselected histories of Mayo Clinic patients was made with a view to comparing the amount of syphilitic infection in railroad men with that of certain other occupational types. Of these histories, 1,657 were grouped under occupational heads fairly representative of the average American citizen. The 1,657 cases included men and their wives, 1,143 of the former and 514 of the latter. The presence of syphilis was demonstrated in these cases by a searching examination in the section on Dermatology and Syphilology following their routine general examination. In connection with the general study a special study was made, based on the records of fifty syphilitic railroad employees, taken at random from the files of the section, with a view to determining if possible the types of late complications most prevalent among them and the methods best suited to the detection of the disease in their examination."

Of the railroad employes examined, 11.7 per cent had syphilis. This was approximately eight times the percentage found in the farmer group (1.5), twice the percentage found among the common laborers (6.1) and three times the percentage found among the business men (3.8). Incidentally the writers believe that their figures throw an interesting light upon "the weakness of unaided clinical judgment in the recognition of this disease." The low percentage of syphilis (3.1) in their group of 1,657 cases is in their opinion due largely to the fact that only the most obvious cases were detected by the general medical examination given to these patients. In spite of the fact that the clientele of the clinic is drawn largely from the farming class, in whom syphilis is apparently relatively infrequent, and from a part of the country in which the percentage of venereal infection is low, they believe that a routine Wassermann test of all their patients would have brought their figures nearer to the currently accepted estimates compiled from the clientele of city hospitals and dispensaries, which average 19.2 per cent.

"The fifty railroad employees whose cases were considered in the special survey included locomotive engineers, firemen, brakemen, switchmen, conductors (excluding dining car), section hands, yard foremen, inspectors, telegraph operators, signal maintainers, and station agents. Men of these types, aside from the responsibilities which devolve on them, form an especially interesting occupational group medically speaking, because they have for years been ostensibly under medical surveillance, and their health record is, therefore, in a sense indicative of the efficiency of the industrial medical practice of the past. To find so high a percentage of the men infected with a grave disease, capable of seriously impairing their efficiency, and through that impairment of bringing discredit on railroad administration and danger to the public, is a matter for concern. To find so much of the infection easily recognizable and yet apparently unrecognized suggests the need for a modern revision of methods and conceptions in medical supervision."

"The doubtful value of the history of infection and the blood Wassermann test in the recognition of these cases is shown by the fact that 24 per cent of the patients gave no history of infection other than gonorrhea; 62.5 per cent had observed no secondary manifestations; and 53 per cent were completely Wassermann-negative on the blood. On the other hand 64 per cent of those whose spinal fluids were examined showed positive findings."

"The age data on the cases furnished two interesting observations. One-fourth of the patients (26 per cent) were infected between the seventeenth and twentieth years, one-third (32 per cent) between the ages of 20 and 25. By their twenty-fifth year nearly 60 per cent were infected; by their thirty-second year 91 per cent were infected. It seems a practical suggestion, therefore, that since the efficiency of the Wassermann test is highest in the early years of the infection, the test could be applied to best advantage to the age group 17 to 25 (60 per cent of infections), on entering railroad service, and repeated in the same group on reaching age 31 (91 per cent of cases).

"The age at which relief for late symptoms is sought suggests the age group which, at the present time at least, should be subject to closest surveillance. . . . Nearly 70 per cent of the men included in this series appeared for examination in the clinic before reaching the forty-fifth year, and one-third between the ages of 35 and 40. Yet two great railroad systems do not begin routine annual examinations until the employee reaches 50 years of age, and six out of eight content themselves with examination once in three years during the very period when syphilis in their personnel is most likely to endanger the lives of the public and of employees."

Sixty-two and five-tenths of the cases examined showed pupillary abnormalities, muscular paralyses, and fundus changes.

"The presence of so high a percentage of abnormal eyes in a group of men whose eyes, of all the structures in their bodies, are ostensibly subject to the keenest scrutiny by railroad medical examiners, was a matter for astonishment. The inadequacies of the average railroad medical eye examination, which seems to be confined to vision and color sense, and the remedial possibilities, suggest themselves at once. At least a clue to the presence of two-thirds of the syphilis we recognized in railroad men could have been had by so simple a procedure as the careful taking of pupillary reflexes.

"Even an extremely simple neurologic examination, such as should properly be a part of any significant medical examination, revealed interesting facts." Abnormal knee reflexes were present in 65.1 per cent of the cases examined and "similarly high percentages prevailed for the other simpler details of the neurological examination. Definite mental symptoms were present in 38.4 per cent."

"The high percentage of mental symptoms is especially interesting. Two patients had amnesic attacks, and it was apparently in one of these that one of the locomotive engineers in our series became responsible for a breach of orders, running past a siding with a resulting collision of his freight with a passenger train. Many of the men were irritable, quarrelsome, inattentive, or fuddled. One patient, a locomotive engineer in charge of a very large and powerful engine, subsequently described vividly his impulses to run engine, train, and all through the terminal station building, and the subsidence of this dangerous irritability following the beginning of treatment. The records of these patients were taken before this study was contemplated and by another department, so that they are reasonably free from subjective interpretations.

"In the effort to ascertain why so large a percentage of serious late syphilis escaped detection in railroad medical examinations, a questionnaire was sent to the medical departments of eight of the largest railroad systems in this country, explaining the purpose of the investigation and asking certain questions relating to their methods of examination. The very cordial coöperation of the heads of these departments, in replying in detail, developed the following facts: All of them require a general physical examination when employees of the types considered enter service. Six of the eight re-examine employees every third year thereafter, and in six the examination is for vision, color sense, and hearing only. Four do Wassermann tests 'on suspicion;' three do not do them; and only one road has a routine Wassermann test, and that on hospital patients only. Six of the eight make no special effort to recognize syphilis in their employees; two

make a special effort, although in one, dining-car conductors and waiters apparently receive more than their share of attention because of the directness of their contact with the public rather than because of their responsibility for the safety of trains. Three of the eight medical departments believe there is little syphilis among railroad men and that what little there is is not responsible for accidents; three could make no estimate; and two believe the disease to be prevalent and an undertermined menace to public safety. Two roads make routine medical examinations of employees responsible for accidents, five make them on suspicion, and one does not. What should properly constitute suspicion was not defined. Four of the roads urge a more thorough examination for syphilis upon their medical staffs, two contend that there would be labor-union objection, and one feels that only clinical detection of the disease without laboratory tests is practicable."

The writers have three suggestions to offer as to how present railroad medical examinations could be improved in respect to the detection of syphilis: "First, routine Wassermann tests should be performed on all employees between the ages of 17 and 25, by a competent state Board of Health laboratory, and repeated on all employees reaching 32 years of age. Second, there should be annual effective examinations of men between the ages of 25 and 40 rather than of men over 50. Such examinations should include more attention to pupillary reactions than is at present given, and should employ those fundamentals of the neurologic examination, such as tests of the deep reflexes, Romberg, etc. These can readily be performed by competent general examiners. Third, formal educational propaganda should be undertaken by railroad medical departments for the education of medical examiners and employees alike to the great significance of syphilis in industrial inefficiency and personal ill health."

The Care of Military Mental Cases. By E. H. Young. *The Canadian Medical Association Journal,* 9 :896-900, October, 1919.

This paper describes the methods of treatment used in the Cobourg Military Hospital, the psychopathic hospital of the Canadian Army Medical Corps in Canada. Architecturally, this hospital of 425 beds is notably lacking in the custodial features that characterize the old-fashioned institution for the insane. Except in two wards, the windows are without any special protection; in structure and arrangement the huts are identical with the standard hut of Canadian military hospitals; there is the usual equipment for ordinary medical, surgical, and laboratory work, for hydrotherapy, electrotherapy, X-ray work, and medical gymnastics. The idea, both in construction and organiza-

tion, has been to make the institution as much as possible like a general hospital. " There are seven medical officers on the staff—a number sufficient to give daily individual medical attention to each patient. All wards are in charge of nursing sisters by day and by night, which accounts in large measure for the absence of violence and unseemly conduct amongst the patients.

" Therapeutic occupation and recreation is carried on chiefly under employees of the Department of Soldiers' Civil Reëstablishment, with a staff consisting of a director, two instructors, and seven ward aids. The work is divided into three grades—namely, bedside occupation, class work on the wards, and employment in the workshops—an effort being made to have the patient progress from the lower to the higher grades. The same personnel direct the amusements, furnishing the music for the recreation-hall events and for the hospital dining room. The importance of the work of the ward aids in arousing and stimulating the attention and interest of patients in danger of sinking into dementia cannot be overestimated. It is scarcely necessary to add that this work is not for the monetary benefit of the hospital; its purpose is solely therapeutic. The nature and amount are prescribed by the medical officer and the effect recorded on the medical charts, and if the product of the patient's efforts has a commercial value, he and not the hospital reaps the twofold benefit. There can be no doubt that for the class of patients in a reception hospital this form of occupation, being under medical control, is much to be preferred to the routine industries of the ordinary hospital for the insane, where the effect of the industries on the cost of maintenance of the institution must be considered."

For physical disabilities, these patients receive the same medical and surgical care and treatment as any other class of patients. The marked interest of the local public in the hospital and its charges has been encouraged, as it is believed that free mingling of the public with the patients " tends to prevent them from becoming institutionalized, counteracts antisocial tendencies, and dispels the feeling of sequestration from the outside world so common amongst those under custodial care."

No patient is discharged until the medical staff have decided that there is no reasonable probability of his recovery or noticeable improvement. When this decision is reached, the patient is brought before the standing Medical Board, who, in recommending his discharge from the service, add " a statement as to whether he is fit to pass to civil life under his own control or with supervision of the social-service branch of the Department of Soldiers' Civil Reëstablishment or whether he should be admitted to a hospital for the insane as a custodial or parole case. . . . The responsibility for making recom-

mendations for the disposal of this class of patient makes unusual demands on the knowledge, insight, and judgment of the members of the Medical Board. During the operation of the hospital, approximately eight hundred cases have come before them, four hundred of whom they have sent to civil life, and no serious incident has come to light in the after history of any of these patients which would tend to reflect discredit on the board's recommendation.

" It would appear, therefore, that in the non-restraint system of caring for mental diseases, the C. A. M. C. has carried the torch farther than it has ever before been taken in this country. The patients have been cared for in a building very slightly modified from general-hospital type with a general-hospital organization. Iron bars, padded rooms, strait-jackets, have been entirely replaced by skilled nursing and medical treatment. No insane patient has been locked in seclusion, and no occasion for mechanical restraint has arisen. Over twelve hundred cases have been admitted and cared for without a suicide, homicide, or serious accident of any kind. Over 50 per cent of discharged passed to civil life under their own control, and a slightly larger percentage were discharged without pensionable disability. Although the hospital is located in a residential section of the town, it has been carried on with no more inconvenience to its neighbors than any other large public institution would occasion.

" The establishment of psychopathic wings in connection with general hospitals, especially in those associated with centers of medical teaching, is probably the most acute psychiatric problem in Canada to-day. Psychiatry is the only medical specialty to the demands of which the general hospital, with a few notable exceptions, has not responded. The need of the general hospital for a psychiatric department is admitted, as is also the fact that psychiatry requires a more intimate association with other branches of medicine for assistance in elucidation and solution of its own problems. The fact that the C. A. M. C. was able to satisfactorily so care for its mental cases under the conditions outlined above lends support to the statement that there is no insurmountable obstacle to operating a psychopathic department in close association with any large general hospital, and only in this way can the civilian insane obtain the same advantages in regard to humane and rational treatment as the military cases have received."

Simulation (Malingering) Not an Adequate Diagnosis. By William A. White, M.D. *The Journal of Nervous and Mental Disease*, 50:209-17, September, 1919.

The general opinion among laymen is that simulation—the " in-

sanity dodge,'' for example—is a common way of trying to escape the consequences of one's acts. On the other hand many experienced psychiatrists and criminologists hold the view that simulation *per se* is a comparatively rare phenomenon, and see in the simulator an example of defective personality make-up and in the symptom an expression of such defect. This article is a defence—or, better, an explanation—of the latter position.

The diagnosis of simulation is generally applied to symptoms that appear to have been assumed by the patient to further his particular ends, usually the avoidance of some disagreeable duty or the escape from some punishment. But, in the first place, the fact that these symptoms will work to the advantage of the patient is no proof that they have been consciously assumed; all symptoms are efforts on the part of the organism that manifests them to protect itself or in some way to further its own ends. This is just as true in the sphere of the psyche as it is at the other levels of activity of the body. The symptoms of the hysterical patient or of the patient suffering from a neurosis are attempts of the psyche to benefit itself in some way, and the patient, unconscious of having brought them about, is no more morally responsible for them than is the appendicitis patient for his symptoms. It is evident, then, that cases of this kind cannot justly be diagnosed as simulation or malingering, since these terms imply conscious purpose.

But there are other kinds of cases in which the symptoms have been consciously assumed. The common tendency is to regard these '' consciously simulating '' individuals as perfectly normal and responsible and to treat them accordingly. This is the attitude which the author especially wishes to combat. His contention is that simulation is an inefficient way of dealing with a difficult situation, an infantile type of reaction to reality, and as such is an indication of a defective personality. To apply the term simulation to a case is therefore an inadequate diagnosis; it is the diagnosis of a symptom, not of the underlying condition that produced the symptom.

In diagnosing simulators as defective personalities, however, the author does not mean to imply that they shall be allowed to escape punishment and so reap the benefit of their malingering. His plea is simply for a more complete and a more sympathetic understanding of such personalities and of the motives that underlie their conduct, and for a treatment of them that will be not merely an expression of hatred and condemnation, but an intelligent effort to sublimate their reactions and direct them to '' higher, socially acceptable, and useful levels.''

THE PREVENTION OF FATIGUE IN MANUFACTURING INDUSTRIES. By Reynold A. Spaeth, Ph.D. *The Journal of Industrial Hygiene*, 1:435-47, January, 1920.

This article discusses some of the fallacies and misconceptions on the subject of fatigue in industry that have tended to confuse the real issue, and suggests " a theoretically sound " program of fatigue prevention.

The various tests that have been devised for detecting fatigue are of little value from a practical point of view because they do not distinguish normal fatigue—which is natural and inevitable after a day's work and from which one recovers overnight or over the week-end—from cumulative fatigue, which leads ultimately to a breakdown and which constitutes the real problem of fatigue in industry. The laboratory tests of the physiologists are qualitative, not quantitative; they do not demonstrate at what point fatigue ceases to be normal and becomes cumulative. Very much the same criticism applies to the use of output statistics as a means of detecting fatigue—they are not a reliable index of over-fatigue. A falling off of output, when not accounted for by other conditions, does indeed indicate fatigue, but in some instances this may be merely normal fatigue. On the other hand, cumulative fatigue is sometimes associated with a high output until the actual breaking point is reached; in which case the mischief has been done and detection of the fatigue by the sudden sharp fall in efficiency is as futile as locking the stable door after the horse is stolen.

Since, then, no reliable method has thus far been discovered for determining just when the boundary between normal fatigue and over-fatigue has been reached, the most rational prophylactic measure is the reduction of normal fatigue to a minimum.

"The simplest point of attack is the working environment. Throughout the early years of the factory era in industry, human organisms were constrained to try to adapt themselves to a great variety of bizarre and unnatural conditions in the working environment. Only recently have workers and employees come to appreciate the economic and hygienic advantages of adapting the far more plastic environment to fit the needs of the human organism." Some of the environmental factors that have to do with fatigue have already become the subjects of highly specialized branches of engineering—illumination and ventilation, for instance; others have been surprisingly neglected. This is notably true of factory seating facilities. " The long-legged, circular-tipped stool, for example, is a physiological abomination."

Another rational and economical method of reducing fatigue is by the intelligent use of rest periods, the duration and distribution of which should be determined experimentally for each individual pro-

cess. "The objection of piece workers to what they fear will be the 'lost time' of rest periods can usually be met by paying for the resting time at a base rate," at least until they learn that "a rest helps production."

The fitness of the worker for his job—his physical, physiological, and psychological qualifications for it—must also be taken into account in dealing with the problem of fatigue prevention. There is great need for the establishment of standard requirements in the matter of these personal qualifications for the various industrial trades and processes. "American industrial conditions are so complex and varied that the physiological standardization of industrial workers in universal terms becomes meaningless. Empirical standardization by industries and processes, however, seems . . . to be logical, necessary, and practical as a health insurance measure." Here the author describes certain simple tests by means of which it is possible to determine empirically the "minimum physical strength," for example, or the "minimum physiological efficiency" required for a particular industrial operation. "At the outset," he warns, "we will probably find, especially where our total number is small, that our minimum strength is too high. Satisfactory operators will appear from time to time who will fall below our minimum figure. But as time goes on we shall gradually reach a figure which becomes increasingly reliable, having been tested empirically by an increasing number of cases. When this end is attained, we shall have a means of reducing necessary fatigue by allowing only those operators who fall within our strength limit to remain on the job definitely."

With regard to psychological tests, the author advises against the use of elaborate psychological apparatus—which is likely to strike the average workman as foolish or irritating—and recommends tests in which "familiar materials—pins, needles, buttons, and cloth in the garment trades, for example—are used."

The article closes with a discussion of the shortcomings of scientific management from the physiological point of view, with especial criticism of "the untrained type of time-study man and certain highly unscientific aspects of time and motion study methods."

Effect of Hookworm Disease on Mental Development of North Queensland School Children. By J. H. Waite, M.D., and I. L. Neilson. *Journal of the American Medical Association*, 73:1877-79, December 20, 1919.

A hookworm survey in the northern portion of Queensland, Australia, was conducted in 1918 by the state, the Australian Institute of Tropical Medicine, and the International Health Board of the Rockefeller Foundation. Stool microscopy showed 21 per cent of the total population and two-fifths of the school children to be infected.

In order to learn whether or not hookworm disease causes mental impairment, 340 children between six and fourteen years of age were selected for physical and mental examination. The microscopic findings enabled a somewhat arbitrary division into three groups to be made: the "heavily infected," the "lightly infected," and the "hookworm-free." The 340 names were then assembled alphabetically into a single list and placed in the hands of a co-worker who had no knowledge of the results of the stool examinations. The Goddard 1911 Revision of the Binet-Simon Scale and the Porteus Mazes were then applied with slight modifications, and scored according to standard methods. After the scoring was completed, the names were again separated into the three groups of noninfected, lightly infected, and heavily infected.

A comparison of group data clearly demonstrates that hookworm disease retards mental progress and impairs mentality. For example, to count backward from twenty to one successfully required an average of two seconds longer for the heavily infected than for the hookworm-free group. Also, in solving the Porteus Mazes, the heavily infected required more time than the noninfected group.

In the Binet-Simon tests, the hookworm-free children gave results comparable with American findings. "By the Binet scale, all combined causes of mental impairment other than hookworm infection produce an average case retardation of 3.9 months, while light hookworm infection gives an average case retardation of 9.3 months, and heavy infection of 23.4 months. The Porteus Mazes gives similar results at a somewhat higher scoring level, which is probably due to the method of scoring. . . . Assuming the hookworm infection and reinfection is of long-standing duration, the results here shown indicate that the disease produces cumulative mental retardation to the extent of 6.6 months at eight years of age, 19 months at eleven years, and 25.9 months at fourteen years of age, over and above ordinary retardation found in noninfected cases." E. K. Strong reports similar observations in his North Carolina study, and C. W. Stiles has shown in hookworm-infected children a cumulative memory impairment and a failure to advance through the grades at normal rates.

The writers summarize their findings as follows:

"1. Hookworm disease in North Queensland children produces measurable mental sluggishness.

"2. Hookworm disease in North Queensland children retards their mental development in proportion to the massiveness of the infestation.

"3. Prolonged hookworm infection appears to produce cumulative mental retardation."

Several tables of statistical data are included in the article, but on account of lack of space, the appendices are omitted. These appear, however, in the reprint of the article.

BOOK REVIEWS

PSYCHOLOGY FROM THE STANDPOINT OF A BEHAVIORIST. By J. B. Watson, Ph.D. Philadelphia: J. B. Lippincott Company, 1919. 429 p.

This book is important both as a students' text and as the confession of a distinctive and progressive faith. From the former standpoint, it is likely that medical students are considered at least equally with collegiate ones. This has the advantage of keeping the discussion closer to concrete issues, to which the book is well held. It is undoubtedly the best systematic text for the former group. As a university text, the viewpoint is probably too distinctive for its wide use as a basis for the elementary course, and is better adapted for collateral study.

The ground covered necessarily departs from that of the usual introductory text. The first chapter is one of formulation, especially as defining the relation of psychology to physiology and to medicine. The second discusses the four chief divisions of psychological methods. In the first category belongs "observation," both with and without instruments; or with and without experimental conditions.[1] From these the conditioned reflex method, in which Watson is specially interested, is separated to form the second category, and described in its simpler applications. The third category concerns the "verbal report" methods, which are coterminous with introspection. The attitude towards these is more liberal than in the original behavior lecture. A fourth category includes methods of (chiefly "intelligence") testing. The following three chapters are concerned with the physiology of sensation, of the nervous system, and of movement. Here, as the author says, is material not wholly continuous with the rest of the volume, and carrying a wealth of detail which comparatively few students will need to master. The thread is resumed in the sixth and seventh chapters, which take up inborn modes of response—i. e., emotions and instincts. It is very serviceable to bring out the relation of the two as is done. In general it is said that the "radius" of emotional activity is limited to the organism itself, while the instinctive includes overt activities. The studies on the genesis of emotional reactions in children alluded to in the *Suggestions of Modern Science Concerning Education* are here described more fully. Some points of

[1] But how does the author square a statement that 1/100 of a second "gives a scientific record which at present is probably a finer measure than we need in psychology" (p. 26) with a dedication to James McKeen Cattell? Let not reaction time "die of a misprint."

detail in this chapter are that something might be gained by linking up the death feint and terror paralysis with the concept of regression; Watson appears willing to regard the sex resistance as one of the original behavior patterns, in which direction the weight of evidence is certainly tending; "Controlled Association Word Reaction" is used in a sense otherwise known as "Free Association," while "Free Association" is made synonymous with "Continuous Association." The blood sugar work on the association test is especially interesting. The dream is accepted as a symbolic indicator of emotional stress. The modification required of Cannon's biological concept of the emotions would seem to lie in recognizing their partly vestigial character.

The effect of experience on behavior is formulated as "habit," either explicit, overt, or implicit—i. e., not readily observable, as *sit venia verbo*, thinking. There is more account of infant experimentation in this field, and of the very valuable work on the economics of practice. The feature in the treatment of the implicit habits is the close connection postulated between thought and language. The following paragraph is most significant:

"Psychologists as a group have not connected up thought with the rest of the process of integration. . . . Some writers make a complete mystery of it; something that we can talk about and discuss. something whose manifestations we may observe, but whose essence we can never discover. Others have considered thought processes as a correlate of cortical activity (a common assumption). They assume that it is something, no one knows quite what, that can go on in the absence apparently of all muscular activity. If our view is correct. it is a constituent part of every adjustment process. It is not different in essence from tennis playing, swimming, or any other overt activity except that it is hidden from ordinary observation and is more complex and at the same time more abbreviated so far as its parts are concerned than even the bravest of us could dream of."

To this and its context did Meyer never even subvocalize "myologizing tautology"!

The tenth chapter reviews the practical problems of the work-curve and the influences of special conditions upon it. A conclusion also reached in Lahy's review of the Taylor System is embodied in a paragraph on page 381. Further material is presented on the economics of habit formation. The final chapter takes up general questions of personal adjustment. Especially valuable is a long series of questions applicable to the analysis of personal difficulties (pp. 399-404). It seems essentially based on psychiatric experience at the Phipps. It is hoped that Watson will elaborate it more in proportion to its worth. He severely criticizes certain phases of commercial characterology, as

Hollingworth has also done, and concludes with a survey of habit disturbances and distortions that rest on the threshold of psychopathology. In all these topics one is struck with the good fortune of psychology that a man of Watson's independence has also been able to get so much from the contact with his colleagues of the Phipps.

So long as the book deals with "assets" and "facts" in Meyerian sense, it is admirable. There is no obscurity; here and there passages catch the light like jewels to make clear in turn the reader's ideas that cluster around. If there is any general sticking point it will be the behavioristic concept. It will be very unfortunate if this is allowed to lessen the other significance of the work. The concept of behaviorism is overvalued by both its protagonists and its opponents. for reasons that may possibly be made plainer here.

The behavioristic character of Watson's psychology is not fundamentally a distinctive feature. Every scientific method is an observation of behavior. Titchener's psychology is no less behavioristic than Watson's; it lays emphasis on different kinds of human behavior, and studies them perforce by different methods, but they are all observations of behavior and cannot in the nature of things be otherwise. Nor in practise does objective psychology get far without recognizing the necessity for that type of behavior that is implicit in introspection or "verbal report." Thus Von Bechterew (*Objective Psychologie,* Leipzig, 1913. p. 31): " . . . *denn die objective Psychologie betrachtet das Wort als eine der Wichtigsten motorischen Reaktionen des Menschen . . . die Untersuchung geschieht aber nicht vom Standpunkte . . . der erlebten subjektiven Zustande, sondern in bezug auf die äusseren Eigentümlichkeiten welche die Wortsymbole und die anderen äusseren Reaktionen aufweisen, und auf den Zusammenhang mit den Spuren von früheren äusseren Reizen.*" And Watson (p. 39): "The verbal report or response is put down in our records of the results of the experiment and is used exactly as the conditioned reflex responses would be used had we adopted that form of experimentation in our test." It hardly seems, however, that competent representatives of the academic psychology did essentially otherwise. And they, too, had their "method of expression."

The conventional Afro-American emerges on the following page. "The behaviorist is interested in the integrations and total activities of the individual." And especially as these activities relate to harmony with the environment. A behaviorist is not one who studies behavior as distinct from one who studies an impossible something else: a behaviorist is one who studies behavior from a certain point of view. The word "behaviorism" is not descriptive of this point of view, any more than the word "intelligence" is descriptive of the so-called intelligence tests, or the word "sexual" is descriptive of the Freudian

theory of the neuroses. "New scientific wine in old linguistic bottles." One could be the most literally orthodox of behaviorists and come as far short as anything in the *Arch. f. d. ges. Psych.* of satisfying the underlying demand of Watson's psychology. Behaviorism does not denote a method of investigation. Objective psychology was not the *raison d'etre* of behaviorism. This was itself a conditioned reaction, not against introspection as such, but against something that had been closely associated with introspectionism—namely, "academic psychology." This association is traced in the original behavior lecture, pervaded with revolt against what is now called the "divorce of the laboratory from life." Contemporary trends in psychopathology, as the growth of procedures allied to psychoanalysis, prevented in those with such contacts the conditioning of hostility to introspectionism; indeed had a contrary tendency, though revolt against the "academic" detachment from reality was not less positive. Watson's revolt was against a fugitive and cloistered psychology, and he chose a behavioristic line of attack because of his dominant experimental interests. Had he been a clinician, the evolution would have more approximated that of Meyer or August Hoch. The position taken is more concerned for contact with reality than for "behavioristic" or "objective" method in psychology. Its consistent maintenance involves responsibility for many problems where introspections—i. e., vocal and subvocal mechanisms—are the essential guide.

A result of this "associative reaction" is polemizing against concepts not unfavorable, perhaps essential to the fundamental argument. "The reader will find no discussion of consciousness" and in reference to such terms as sensation, perception, attention, will, image, and the like, "I have found that I can get along without them, both in carrying out investigations and in presenting psychology as a system to my students." One can investigate fluorine without reference to oxygen, write a text on meteorology without mentioning rain, administer a mental hospital without restraint. How efficient or desirable it may be to do these things depends on circumstances. What Watson accomplishes is a comprehensive review of that portion of psychology where this taboo gives the least inconvenience. Topics like autism, symbolics, or dissociation would lend themselves less handily to such restrictions. From the older terminology, Watson has "retained such terms as thinking and memory," like the aboriginal who buries with the body all the effects of the deceased except his axe.

It is hoped that this review is itself testimony to the stimulating and suggestive character of its object. Watson's style is clear, cold, and vigorous like an upland river. And if at one point there has appeared also the depth commonly attributed to such streams, be it remembered that behaviorism is a "young" river, which has had

little time to smooth its channel. This obstruction passed, there will be no lack of tributaries. As no one else, Watson has vitalized systematic psychology in contact with life and work.

F. L. Wells.

Business Inspirations. By Christian D. Larson. New York: Thomas Y. Crowell Company, 1919. 163 p.

Mr. Larson is the author of the "Larson Books." Twenty-six are listed up to the present time, among them *Brains and How to Get Them,* "Declared by experts to be a truly remarkable book;" *Great Within,* "The best book on the subconscious mind ever published;" *Just Be Glad,* "If you want sunshine and gladness, this book will give you the secret;" and *Poise and Power,* "Methods that will cure all nervousness and increase your working capacity."

The measure of the present book can be obtained from the first page. The book starts with a rush—"Without the vision, no real attainment is possible. . . . Give your mind freedom to break bounds and encourage your thought to transcend every form of limitation. Nothing but good can follow. Turn your attention upon the highest and most perfect ideals that you can possibly picture and you will positively rise in the scale. Even though you may make mistakes in the beginning and seem to lose hold upon the tangible things in your present sphere, do not ignore the greater ideals before you. Follow the vision. You are simply letting go of lesser things in order that you may gain possession of greater things. He who follows ideals can never be lost, can never go astray, can never fail. Do not waste your spare moments in idle thinking; use such moments for the creation of more lofty visions and splendid ideals. During such moments let your mind take flight to realms transcendent and sublime. . . . Follow the vision whatever comes or no; mount upon the wings of your most lofty ideals; continue to soar toward the great goal you have in mind, regardless of what circumstances may dictate or demand; and one of these days there will be a most happy surprise in store for you; you will find that the greater powers of genius and talent have been born within you; and you will find that your work has become a necessity to the welfare of the world."

How we wish we could write like that! We did something like it in our high-school days. But disconcerting things that were told us in college, together with pulling things to pieces and patching things up in medical school and several years studying those who do not use their spare moments for thinking, but to hitch up their visions a notch higher, spoiled it all. We were once fond of some of the men who pointed out roads to us, but we were deceived. Had they let us

alone in our glorious adolescent naïveté, we might have been writing our fifty-seventh book instead of writing a review. "To-day your soul is stirred by the works of those wonderful gifts they [geniuses, etc.] have mastered so well. To-morrow the world may look to you." (Mother once thought so, and we were going to be president. But now we are only a psychiatrist.) When we work, we should " work in the conviction that we are generating energy faster than we are using energy." We should know that we are "backed up by limitless power, therefore will become neither weak nor tired." (Readers will not need this information; the passage is quoted for the benefit of the stenographer, typesetter, and proof readers.)

But there is an awful jolt in this book of cheer-up. The conscientious reader who goes carefully over each page may not get the full force of it. But not being conscientious, we skipped and our finger fell to page 93. Our cart of visions was hitched to the star, but——

"When we analyze the lives and actions of men who are trying to do things, we find that practically all failures . . . can be traced ultimately to one primary cause—the lack of mental strength, or the giving way of mental strength. Whatever the failure may be, or whatever the immediate or secondary causes may be, the real cause of it all will be found to be the absence of sufficient mental strength to see the thing through to final success. If a man fails to get on in the world, fails to advance as he might, or fails to realize his ambition, he may be assured [some assurance] that the lack of mental strength or the presence of mental weakness in some form is at the bottom of his trouble . . . if he does not possess the required amount of mental strength to push through what he has undertaken, failure will be inevitable." (Assurance, all right, but how about collecting on the vision insurance?) Again, " The man who becomes disappointed when things go wrong, or who loses his courage during trying moments, does so because he is not mentally strong." All right, but where do we go from here?

And after two more pages, "No matter how well you may be equipped in other ways, or how well trained or able you may be, if you are not mentally strong, you will only apply a fraction of your mental or personal equipment; in consequence, you will find it difficult to get on as you would like; or if you are getting on fairly well, you will hardly advance beyond mere prosaic existence." Have a heart, Larson, have a heart! Why rub it in? (Further quotations might demoralize the stenographer, typesetter, and proof readers.)

But there are twenty-seven of these books, and I don't doubt they all have a punch. One gathers this from what readers say on the cover slip. (Cover slips are frequently more interesting than books; one wonders why those who write the cover slips do not write the

books.) Some one from Montpelier, Mississippi, testifies that one of the books has been a "great help and inspiration;" another grateful reader in Los Angeles says it is "the best book I ever read;" a kind friend in New Orleans recommends the books "to the whole human family;" while one in Bridgeport, Ohio, "would not exchange them for all the other books in the house."

FRANKWOOD E. WILLIAMS.

DYNAMIC PSYCHOLOGY. By Robert Sessions Woodworth, Ph.D. New York: Columbia University Press, 1918. 210 p.

In this volume the Jesup Lectures for 1916-1917, given at the American Museum of Natural History, are reproduced with "some enlargements and modifications." It is not a systematic discussion or a text in psychology, but presents the author's points of view in regard to some of the fundamental and more general problems of psychology. The chapters deal with the following subjects: I, The Modern Movement in Psychology; II, The Problems and Methods of Psychology; III, Native Equipment of Man; IV, Acquired or Learned Equipment; V, The Factor of Selection and Control; VI, The Factor of Originality; VII, Drive and Mechanism in Abnormal Behavior; VIII, Drive and Mechanism in Social Behavior.

As is indicated by the title of the book, its distinctive feature is the emphasis on the "driving" forces of the organism. The author recognizes two general problems—the problem of "mechanism" and the problem of "drive." "One is the problem how we do a thing, and the other is the problem of what induces us to do it." His discussion of these matters is suggestive in many particulars, but it is questionable whether it represents any advance over the current and for the most part unsatisfactory discussions of the problems of instinct and learning. After briefly describing the mechanism of the simple reflex, in which energy "stored" in the muscles is liberated by external stimuli and "nerve impulses," the author remarks: "The whole reflex mechanism, consisting of sense organ, sensory nerve, center, motor nerve and muscle, can be thought of as a unit; and its drive is then the external stimulus." (p. 38)

If the author had held fast to this initial distinction between the stimulus as "drive" and the mechanism as the organism, his discussion, it seems to the reviewer, would have been less ambiguous and more promising; but he soon abandons the distinction because it does not seem to him to account for "motive," which he regards as something internal to the organism and the only drive he has thus far recognized is "external"—i. e., the external stimulus.

"If all behavior were of this simple reflex type, and consisted of

direct responses to present stimuli, there would be no great significance in the distinction between drive and mechanism. The drive would simply be the external stimulus and the mechanism simply the whole organism. On the other hand, what we mean by a 'motive' is something internal, and the question thus arises whether we can work our way up from the drive as external stimulus to the drive as inner motive.'' (p. 38)

Instead of trying to ''work up'' from an external stimulus to an inner motive, this would seem to be the place to introduce the current concepts of ''internal'' as well as external stimuli—e. g., the deficit stimuli or the hungers of the organism to account for the motives of the organism.

The following comments may be made on the author's thesis:

The force of a reflex such as the knee jerk may, as the author notes, not be due solely to the local stimulus, but may be reinforced or weakened by other concurrent external stimuli; but this is certainly not a case of ''one nerve center furnishing the drive for another,'' since both have been set off by external stimuli. Neither does the fact next noted—that the activity of a nerve center may outlast the stimulus which aroused it, or that, on the other hand, the center may only be ''sub-excited'' by a stimulus and still be capable of influencing other centers by way of reinforcement or inhibition—bring us any nearer to a ''motive'' that is ''internal'' to the organism. The activity of the mechanisms, however complicated, is a resultant of the interplay of stimuli.

Finally the distinction of Sherrington between preparatory and consummatory reactions, which the author adapts as a further illustration of one mechanism becoming the drive of another, does not help us to ''work up from the drive as an external stimulus to the drive as inner motive,'' but only serves, as it appears to the reviewer, to reinforce the necessity of positing internal—e. g., deficit—stimuli. The sight of prey ''arouses a *trend** toward the consummatory reaction of devouring it.'' ''That there is a *persistent inner tendency* towards the consummatory reaction is seen when, for instance, a hunting dog loses the trail; if he were simply carried along from one detail of the hunting process to another by a succession of stimuli calling out simple reflexes, he would cease hunting as soon as the trail ceased or follow it back again; whereas what he does is to explore about, seeking the trail, as we say. This seeking, not being evoked by any external stimulus (but rather by the absence of an external stimulus) must be driven by *some internal force;** and the circumstances make it clear that the inner drive is directed towards the capture of the prey.'' (p. 41) These ''trends'' and ''persistent inner tendencies''

* The italics are the reviewer's.

by which, under the name of consummatory reactions, the author ultimately accounts for human desires or motives, palpably do not derive their "drives" from the preparatory reactions. The dog hunts because he is hungry; that is, his mechanisms are kept active by an "internal" deficit stimulus, which must be included among the drives of the mechanism.

The author concludes this discussion in the following passage:

" 'Drive,' as we have thus been led to conceive of it in the simpler sort of case, is not essentially distinct from 'mechanism.' The drive is a mechanism already aroused and thus in a position to furnish stimulation to other mechanisms. Any mechanism might be a drive. But it is the mechanisms directed towards consummatory reactions—whether of the simpler sort seen in animals or of the more *complex sort exemplified by human desires and motives—that are most likely to act as drives.* Some mechanisms act at once and relapse into quiet, while others can only bring their action to completion by first arousing other mechanisms. But there is no absolute distinction, and it will be well to bear in mind the possibility that any mechanism may be, under certain circumstances, the source of stimulation that arouses other mechanisms to activity." (p. 42)

There is no question, of course, but that one mechanism of response, once aroused to activity, may affect the discharge of other mechanisms, or that the discharge of the first mechanism may be preparatory to or may condition the discharge of a second, third, or more, but the series of responses or motor sets is in every case initiated by an external or internal stimulus. The latter are the "drives" of the organism. A mechanism is not self-initiating, and is never the *source of stimulation* that arouses other mechanisms to activity.

The neglect of this distinction by the author affects much of his subsequent discussion. His treatment of the "native and learned equipment" of man differs little from the current treatment of, for example, McDougall, whom he quotes with approval. In this psychology, instincts replace the faculties of the soul as entities or mechanisms which furnish their own drives. The author accepts for the most part McDougall's list of instincts and is quite ready to admit of such verbal entities as "curiosity," "the instinct of construction," and "the gregarious instinct" as mechanisms which of their own initiative drive the organism. He would even go a step further and add to the list the so-called "native capacities"—to wit, on pages 66 and 67. "But if we inquire whether McDougall could be induced to include what we have called native capacities in his list of instincts, we readily assure ourselves that he would not. To include them would lie quite outside of his scheme. They belong rather with those intellectual processes which he asserts to be the servants of the

instinctive impulses; to be, in short, mechanisms requiring drive, and not by any means drives themselves. This is the chief point at which the present discussion takes issue with McDougall; indeed, disagreement on this point is the chief element of contention in this whole book. The great aim of the book is, that is to say, to attempt to show that any mechanism—except, perhaps, some of the most rudimentary that give the simple reflexes—once it is aroused, is capable of furnishing its own drive and also of lending drive to other connected mechanisms. The question is whether the mechanisms for the thousand and one things which the human individual has the capacity to do are themselves wholly passive, requiring the drive of these few instincts, or whether each such mechanism can be directly aroused and continue in action without assistance from hunger, sex, self-assertion, curiosity, and the rest."

A further quotation will show the general drift of the book:

"The instincts are adaptations to very general features of the environment, while the capacities are adaptations to more special features. Curiosity, for example, is a native adaptation to an environment that changes and continually presents something new; its behavior consists in the exploration of what is new. The capacity for perceiving number relations is an adaptation to a more special feature of the environment; its behavior consists in counting, adding, subtracting, and performing more complicated arithmetical operations. This number behavior is scarcely present in animals; it represents a specialized adaptation that is characteristically human." (pp. 74 and 75)

With such specialized, ready-made adaptations, there can remain little to be said about the learned activities of the individual. The author begins his discussions with a "clear case"—"Laughing is a movement that does not have to be learned"—and concludes that "while we laugh by nature, we learn what to laugh at." He recognizes the principle of the "conditioned reflex"—"a reflex aroused by some other than its natural stimulus" as a result of the secondary stimulus having acted concomitantly with the natural or biologically adequate stimulus—as a "type of learning which accounts for a large proportion of an acquired equipment," and cites an interesting passage of examples from Locke's chapter on the association of ideas. In this connection, the author remarks that "Locke's way of stating his case is rendered somewhat unpalatable to the modern student by his broad and vague use of the term 'idea,' and his always speaking of the connection of ideas when we should speak of the connection of stimulus and response . . ." It is but fair to inquire in how far the author's own use of "mechanisms" differs essentially from Locke's "ideas," and whether he also speaks sufficiently in terms of the connections of stimulus and response.

Besides the association of old reactions to new stimuli, pertinent examples from comparative psychology are cited of the *dissociation* of reactions from their natural stimuli. Had these principles been applied earlier in his discussions, much of what the author considered native equipment might be analyzed into "clear" examples of the conditioned reflex. The possibility, for example, of even some of the "fundamental coördination of muscular action" being *learned* during the embryonic period is quite as tenable an hypothesis as to assume that they are "provided by nature." The latter point of view admits of the wider possible influences of environment and training; its significance and promise for education and mental hygiene should be apparent.

In the concluding chapters of the book, the author applies his principle of self-driving mechanisms to a discussion of the essence of genius and of abnormal and of socially efficient behavior. "*The drive behind the industry of the genius is not the drive* of hunger, or sex, or rivalry—though any of these may contribute incentive—but is to be sought within the activity itself." (p. 132) We should rather accept a previous statement of the author that "if there is any other fact to be observed in a distant view of genius, it is perhaps a remarkable keenness of perception in the field peculiar to any individual genius," and, granting the inherent superiority of the organism, we should be inclined to maintain that its driving forces are of the same nature, if not of the same degree, as in other human beings, and that its particular "interests" are learned on the principle of the conditioned reflex.

The discussion of abnormal behavior is essentially on the descriptive rather than the explanatory level. "We have to suspect, in each case, that there is some *drive* behind the development of the abnormal reaction. It will be fundamentally a normal drive, one that operates in all men. We have to suspect also an *obstruction* barring the way to the goal towards which the drive is directed, an obstruction internal to the individual and due to weakness in his make-up. Thus involved in a puzzling situation, he goes through a *trial and error* process, and, being unable because of his own weakness to find a really appropriate solution of the problem, adopts some *substitute* solution that gives an illusory success, and thus satisfies the drive and permits its tension to relax." (p. 161) Obstruction and substitution are explanatory principles whose mechanisms the author fails to lay bare. The mechanism of the conditioned reflex is reviewed, but the author concludes that a "fully fledged neurosis is more complex than a conditioned reflex." The Freudian concepts are viewed critically by the author. "The main points of the Freudian psychology—infantilism, the importance of sex impulses, and repression into the

'unconscious'—all have an element of truth, but are all overemphasized . . . The 'unconscious' is certainly overdrawn. . . . And as to the sexual impulse, it is only one among many tendencies that drive human activity." (p. 168) "Freud formally admits, indeed, two motive forces, sex and the 'instinct of self-preservation,' but our consideration of instinct revealed many more than two tendencies in native equipment, and the reality of learned or acquired drives must also be insisted on." (p. 168)

The inherent defect in the point of view of the book is nowhere more evident than in the final chapter on social behavior. The entity that drives the mechanism in this case is the "social motive." The author does not like to call it an instinct—"It would be ill-advised to speak of a social *instinct* underlying this behavior . . . " (p. 203)—so he calls it a capacity. "The social gift is a capacity for learning social behavior." (p. 205) "The first sign of the social motive in the infant is his attention to other persons." (p. 203) The infant also attends to lights and sounds; why not assume that he also has a "light motive" and a "sound motive" and a "baby-rattle motive," etc? If stimulus and response are sufficient to describe the reactions to physical objects, are they not sufficient to describe "social" behavior?

Finally, then, despite the use of newer terms, the author comes out with a faculty psychology. He began with the external stimulus as the "drive" of the bodily mechanisms and ends with certain verbal entities or "motives." In a word, he has not established his thesis that a mechanism may become a drive; it is an application of the theory of perpetual motion to psychology and was doomed to failure. His criticism of Locke's use of the term "idea" applies to his own discussions; he is speaking of the connections of interdriving mechanisms, when we should speak of the connection of stimulus and response. The practice of education and mental hygiene may be based on the latter methodology with some assurance, but hardly on the former.

WALTER F. DEARBORN.

PERSONALITY. By Harry Collins Spillman. New York: The Gregg Publishing Company, 1919. 206 p.

The book is composed of nineteen talks given by the author, mostly before pupils in the New York City high schools. The author was formerly a specialist in commercial education for the Federal Board for Vocational Education. The talks were given under the auspices of the New York Board of Education and the New York Chamber of Commerce. In addition to the text there is at the end of each chapter a questionnaire intended to emphasize points in the talk and to stimulate

the student to a further inquiry into the subject matter, and a short list of books for additional reading. Good judgment has been shown throughout—not only in the tone and content of the discussions themselves, but in the length of the chapters, the type and length of the questionnaire, and the number of books assigned for reading.

The book is free from bombast and twaddle. The young student is not urged to run breathlessly after "visions." The value of ideals, of self-confidence, of ambitions, of imagination are emphasized, but at the same time it is quite definitely pointed out to the young reader that it is "important to distinguish between the limp wishing for success and having a definite, clear-cut mental pattern of the object to be achieved. Wishing will bring things to pass only to the extent that it may inspire and energize you to go after them." One regrets, however, a false note struck in the chapter *My Ships,* a chapter on the value of imagination: "If we are possessed of an ideal, it must be because we have in us the possibility of it. God does not put into the wild geese the instinct to go south in winter without a south to go to. He did not inspire Columbus to sail without a San Salvador on which to land." Such reasoning is not likely to be convincing even to a pupil in the high school. In the questionnaire at the end of this chapter one finds also: "Have you ever looked into the starry sky and thought that 'the face of nature would not be so serene and beautiful if man's destiny were not equally so'?" Throughout the book, Mr. Spillman has given the young warrior real instruments for his work. Why does he load him down with this *papier-mâché* gun? But in the same chapter one finds one of the most charming illustrations of the value of imagination and of youthful ambitions that it has been our good fortune to run across in some time—a personal account of the author's desire for a roll-top desk, the influence this ambition had upon his life as a boy and young adult, and finally the steps by which the desk was attained.

The chapter *Tides of Life,* in which the author takes some of the discouragement from "There is a tide in the affairs of men," will be helpful. Using as the basis of illustration the relative value of the home run and the sacrifice play in baseball, the necessity is pointed out of going from first base to home by way of an orderly succession of bases, but with the determination not to "die on third." "Success consists not in getting away on the first great swell of the sea with never a calm, never a halt, never a plateau where the mileposts are set in for our inspection and marking." There will be the haltings and plateaus, but it is important chiefly that they be marked, "Cable crossing, do not anchor!" One may pause for breath and inventory, but "the rising sun should bring a fresh perspective." A brief sojourn in these epochal places will hearten and strengthen against the

final try, but the North Star must not be lost out of the perspective. And here is quoted effectively Pat O'Brien's apostrophe to the North Star at a time in his escape from Germany when he had lost his way and was greatly discouraged. Whether the younger readers will note it or not, an older reader enjoys in this chapter the quotation from Barry Pain, the humorous philosopher: "There are so many pleasant halting places this side of perfection, I have a great tendency to get off at the next station."

In the reading lists at the end of chapters are found both old and new friends. Among the former are Henry Drummond's *The Greatest Thing in the World* and Russell H. Conwell's *Acres of Diamonds.* We remember these as stimulants in our own adolescence and we must reread them to see if they still have power and to discover the source of that power. As we remember, they were something in the nature of rather general directions for following the green line through the subways of life to the shuttle for the Times Square of Heaven, but we are not sure. Thorndike's *Individuality,* Tsurn Arai's *Mental Fatigue,* Crother's *The Lords of Destiny,* Pope's *Essay on Man,* James J. Putnam's *Human Motives,* Ruskin's *Essay on Work,* and Josiah Royce's *The Psychology of Loyalty* are recommended among others, a list much superior to that usually found in books of this type.

Mr. Spillman has achieved a difficult task. He has sailed his book successfully between what is too difficult on the one hand and what is silly and even dangerous on the other. We can probably pay him no greater compliment than to say that one copy of the book has already gone forward to a young friend recently graduated from the high school and that we expect to make use of several additional copies.

FRANKWOOD E. WILLIAMS.

SYPHILIS. By Henry H. Hazen, M.D. St. Louis: C. V. Mosby Company, 1919. 647 p.

Neurosyphilis plays such a large rôle in the study of nervous and mental diseases that any book dealing with the subject of syphilis must of necessity be of interest to those occupied in the field of neuropsychiatry.

This book by Dr. Hazen is most satisfactory from many points of view. The author recognizes, as he states, that syphilis is such an all-embracing subject that no one man can hope to be an authority on all its phases. Hence he has associated with himself a number of specialists who have contributed chapters relating to their special fields. The book has more unity than is found in the usual system written by a number of individuals, because in this instance the author

apparently has been the dominating force and has asked people to write a chapter rather than to attempt to contribute a special article.

The book contains a very great amount of material on the whole subject of syphilis, such as could be found, probably, in no other book of similar size. It is all written in a logical, comprehensive, and technical manner, so that one feels that one has a resume of the latest knowledge in the field. This book very satisfactorily affords the neuropsychiatrist the information about syphilis in its various stages and manifestations necessary to him if he is going to have a clear conception of its relation to neuropsychiatry.

The chapter on syphilis of the nervous system is contributed by Dr. John E. Lind, Senior Physician at Saint Elizabeths Hospital, Washington, D. C. About sixty out of the six hundred and forty-seven pages of the book are devoted to neurosyphilis. This subject is thus given a much more ample consideration than is ordinarily found in textbooks on syphilis. The subject that Dr. Lind treats has, of course, been given entire volumes by other authors. This indicates that although sixty pages is more than is ordinarily devoted to the matter in a textbook on syphilis, it has necessitated a considerable degree of brevity on the part of the contributor. Because neurosyphilis embraces rather technical matters related to psychiatry and neurology, it is fairly difficult in the space of sixty pages to give an adequate picture to people who are not trained in these specialties. However, this has been done very successfully and represents our modern ideas on syphilis of the nervous system. The literature is fairly well covered, and there is much interesting historical data on the discoveries of neurosyphilis, both remote and recent. One must say that the portion on neurosyphilis is very well done and quite satisfactory. One cannot help feeling that one would have wished the author to have brought more of his own personality into the chapter. He has covered the current theories and opinions very adequately, but has not done quite as much as he might have done in interpreting these theories. In certain places he has come out dogmatically. This is to be commended, as the person not a specialist in the field is given a point of view he can accept as authoritative. Thus, in regard to the care a syphilitic patient should have in order to prevent the appearance of symptoms of neurosyphilis, the statements are forcible, and should be praised. For instance, the following sentences, which have been written as a result of the author's experience, may be quoted: "The physician should tabulate all the cases of syphilis in his practice and *examine them at regular intervals during their lifetime.* . . . In cerebral syphilis, tabes, and paresis, the first symptom to appear may be . . . pleocytosis; it may occur as long as two years before any neurological

symptoms are demonstrable. These patients should be impressed so forcibly with the idea that this examination is indispensable to their welfare that they submit themselves to it regularly and voluntarily. This routine investigation should include a review of the patient's activities since the last examination, . . . a testing of the chief reflexes, special attention being given to the pupillary reflexes, a Wassermann reaction with the blood serum, and a complete examination of the cerebrospinal fluid. Such a routine examination, including the fluid examination, should be made once a year, and, if possible, the same examination, exclusive of the fluid, every six months." If this advice by Dr. Lind should be thoroughly carried out, a great deal would be accomplished in the prevention of the late manifestations of syphilis of the nervous system.

Some criticism may be offered in regard to the logical sequence of the discussion. One does not always quite follow the relation between the pathological lesions, the symptoms that arise therefrom, and what could be hoped for as a result of treatment. Nor is the treatment of cases of neurosyphilis made sufficiently clear. If one were not already in possession of the information as to how to handle the special problems of neurosyphilis, he would hardly receive enlightenment from this chapter.

As the author himself points out, classification in the realm of neurosyphilis is very confusing. It is to be feared that he has not helped to classify. Thus he has headings of meningitis of the base, meningitis of the convexity, and cerebrospinal syphilis, and one cannot be sure what his points of differentiation are. Nor does he make himself clear in the debatable use of the term parasyphilis.

There are a few inaccuracies, such as the quotation that arsenic has not been found in the cerebrospinal fluid after intravenous injections of arsphenamine. These faults are not serious, however, and do not greatly detract from the value of the work.

Our main criticism is that there is not enough of Dr. Lind in the chapter. It would have pleased us better had there been a little more dogmatism, a more didactic approach, or at least if the contributor had acted as an interpreter of the many authorities he has quoted, especially as they are so often at variance.

These criticisms are merely by the way, as it were. The article is quite worth while and probably gives the best summary of the subject in its modern aspects that can be found anywhere. The chapter on neurosyphilis, as the whole of the work, is written for the medical man and not the layman. For the latter it is too technical, but the physician will find this work well worth reading.

H. C. Solomon.

ORIGINALITY: A POPULAR STUDY OF THE CREATIVE MIND. By T. Sharper Knowlson. London: T. Werner Laurie, Ltd., 1918. 304 p.

Originality, by T. Sharper Knowlson, has been well named by the author *A Popular Study of the Creative Mind.* He says in the preface, "I have addressed myself to students of the more thoughtful type, not to psychological students, except in so far as all intelligent people are nowadays included in that category." A sad blow to the trained psychologist who has won his doctor's degree by dint of hard laboratory labor! One might warn these same trained psychologists against reading the introduction, in which the author scorns the trend of modern psychology, which leads only to "speculative" issues and "gives attention to the static conditions (of the mind) rather than its fundamental dynamic qualities." "It is unwise," he adds, "to spend money and labor on the aspects of the knowing process when the mind's creative aspects are awaiting the first signs of serious attention on educative lines."

The object of the book is stated as follows: "First, to show the importance of creative thought and develop an interest in it; next, to offer some suggestions as to the natural history of mind in its most inspired moments; finally, to institute a régime for the individual whereby he may secure the highest mental efficiency."

Originality, according to the author, is not a gift needing neither training nor experience, nor is it merely "something new," but it is expression of the individual self in relation to its environment. The author's chief interest lies in the intellectually new and striking, rather than in originality in character and conduct.

Section I of the book deals with the natural history of genius and the source of the originality of original minds. The consciousness of the man of genius is described and the rôle of the subconscious in productions of the creative mind. The mind of unusual powers, as the creative mind is termed, is distinguished from that which is conventional or commonplace by its greater range of consciousness, rather than by a difference in mechanism. Section II deals with the origin of new ideas. Inspiration is described as a natural process, and six formulæ are offered for inducing inspiration. Section III deals with biological factors—the effect of age and sex on originality. In Section IV the hindrances to originality are discussed, which are to be found in too great a reverence for tradition, in the overplus of masculine influence and dogma in the home, in the neglect of our educational procedure to do justice to the exceptionally bright child and the overemphasis on knowledge over originality, in undue dependence of people in general on books, and in the incomplete effort associated with low

standards of merit. (The author suggests that book reviewers be more severe in their criticism!) In this section and in Section II may be found the constructive contribution of the author on the subject of originality. Section V considers the possibility of originality in the future. In spite of the pessimism of such men as Spencer, Ferrero, Lange, George Moore, and C. H. Pearson, Knowlson is optimistic regarding it. Section VI is a heterogeneous collection of some reflections on mental attitudes and methods, beginning with a quotation asserting that since the Age of Pericles only one in 450,000 men could be called distinguished, and ending with a plea for more men of vision.

The book is largely composed of quotations and illustrations from innumerable sources to substantiate the assertions of the author. While this method results in much entertainment for those who are not familiar with the various sources of supply, it is unsatisfactory for those who have read widely and who are searching for more than a popular study. Considered as the latter, however, the book will be a source of much entertainment for the casual reader, and he will find in it suggestions which may stimulate his creative effort.

EDITH R. SPAULDING.

RURAL PROBLEMS OF TO-DAY. By Ernest R. Groves. New York: Association Press, 1918. 181 p.

Virgil Jordan contributes to a recent number of *The Dial* a suggestive article, "The New Psychology and the Social Problem," in which he discusses the contribution the newer psychology has to make to economic, sociologic, educational, and religious discussion. Jordan regrets that so few leaders of current discussion in these fields are familiar with this material. Veblen, Marot, and Tead, he believes, are the only contributors who thus far have shown any familiarity with or understanding of the significance of the data being brought forward by the psychiatrists. Jordan's list is essentially complete, so far as we know, but it so happened that his article and Professor Groves' book were read on the same evening and it was found at once that the name of Groves could be added. To be sure, Professor Groves in this book is not dealing with the same major problems as Veblen, Marot, and Tead, but he is dealing with an important subject—rural life—and a long neglected subject.

The author in his preface states frankly that his effort is to approach "rural social life from the psychological angle," and it is found that whether he is dealing with the family, the home, the schools, or the church, his effort is to understand these institutions and their effect upon rural life in the light of the newer psychological data. In an earlier book, *Using the Resources of the Country Church*, Groves reflects the same point of view. In both books the significance lies not

in the fact that certain chapters are included that deal directly with mental problems—for example, "Mental Hygiene in Rural Districts," "Psychic Causes of Rural Migration," in the one, and "The Church of the Small Community and the Conservation of Mental Health," "The Church of the Small Community and the Problem of the Feeble-minded," in the other—but in the fact that in each the psychological aspect is nowhere lost sight of. As the author states, "the purpose of the book forces it from the well-beaten pathways," but this effort to give emphasis to the mental side of rural problems does not lead the author to discount the other significant aspects of the rural environment.

One looks forward to a textbook of sociology by Professor Groves, feeling sure that it will bring to the study of sociology the point of view Jordan and other students find lacking in the current discussions.

FRANKWOOD E. WILLIAMS.

AN EXPERIMENTAL STUDY OF ATTENTION FROM THE STANDPOINT OF MENTAL EFFICIENCY: A CONTRIBUTION TO EDUCATIONAL AND SOCIAL PROBLEMS. By Shoan Masuzo Fukuya, Ph.D. Princeton: Psychological Review Company, 1918. (Psychological Monograph No. 110.) 42 p.

Pedagogues of a formal turn of mind are apt to be strong advocates of the value of " concentrating " the attention, usually without giving much indication as to how the trick is done. So Meumann: " The more intensively a person concentrates his attention upon his act of learning, the sooner will he succeed." Paying attention to how hard he is working may, on the contrary, merely distract the worker from the task in hand.

The author of this monograph shows, by means of painstaking experiments with a group of ten adults—chiefly graduate students—and about fifty children, that work done when extra efforts were made to " concentrate " was not more effective than when the work was attended to in the way in which the subjects were accustomed to attend to their tasks.

His chief conclusions are indicated in the following passages:

" Educational theory has frequently assumed that the efficiency of work can be materially stimulated by the teacher by the demand for extra-attentive effort on the part of the students. Teachers are prone to demand that students pay extra attention to their tasks, to work with effort or a high degree of mental tension. Mature students likewise assume that they can increase their efficiency by voluntary effort, by an attitude of mental tension, or, in popular language, by voluntarily concentrating their attention on the task at hand.

"It has been our purpose to test the validity of this assumption in three types of activity. Subjects were requested to perform tasks of equal difficulty with two different mental attitudes—their customary or usual attitude, and one representing a high degree of mental effort and attention. . . .

"The results disprove the assumption in the main. Voluntary effort made under conditions such as these in this experiment (comparable with many situations in school and industrial life) may be slightly stimulating in limited circumstances, but it is doubtful if the extra efficiency attained will compensate for the additional energy and strain expended."

WALTER F. DEARBORN.

THE CARE AND CONTROL OF THE MENTALLY DEFECTIVE AND FEEBLE-MINDED IN ONTARIO. By Honorable Frank Egerton Hodgins, Justice of Appeal, Commissioner. (A report printed by order of the Legislative Assembly of Ontario, 1919.) 236 p.

This report embodies the results of the investigations of the commissioner into the facilities available and the methods used for handling the problem of mental deficiency in the province of Ontario, and also a detailed account of "the extensive work carried on and projected elsewhere both in Britain and the United States." In a series of twenty-one sections or chapters, practically every phase of mental deficiency is covered in detail, the topics ranging from feeblemindedness as a state problem, definitions, delinquency, and so on, to a discussion of practical policies as to supervision, building and equipment needed, special classes, court clinics, regulation of marriage and immigration, etc. The report is rather unique in the extensive quotations from various writers, reference frequently being made to many of the leading authorities on mental deficiency in the United States. Supplementing the report is a series of twenty appendices, consisting of a number of papers and reports of commissions upon various aspects of mental deficiency. The whole has resulted in a statement of fact and a program that is both conservative and eminently modern in point of view.

A program is recommended, which is familiar and in a sense standardized, admittedly desirable, and, where the most accepted methods are in use, in various degrees of being put into practical operation. This program calls for a board of control or commission, under whose administration shall be carried on the identification, classification, registration, supervision, and other phases of the care of the mental defective. Practical provision should be made for observation hospitals, court clinics, community clinics, colony care with facilities for

industrial and manual training, special classes in the schools, licensing of private institutions, and inspection of all institutions.

Recommendation is also made that the jurisdiction of the juvenile court, which now stops at the age of sixteen years, be extended to all under twenty-one. More adequate provision "for the permanent segregation of feebleminded women of child-bearing age" is advocated, but not necessarily in institutions in the ordinary sense, consideration being given to the practicability of establishing colonies similar to those maintained by the Rome State School of New York. In this connection, the enactment of legislation prohibiting the marriage of mental defectives who have been identified and registered is regarded as desirable.

It is gratifying that the necessity for the identification of all mental defectives at as early an age as possible is recognized and repeatedly emphasized, if success is to attend efforts towards prevention. In this respect, the activities of the schools are extremely important. Furthermore, "the education of more medical students in psychiatry and psychopathy is a pressing need and a postgraduate course should also be provided. It is a matter of common knowledge that specialization in this department of medicine is confined to comparatively few of the medical profession. If any rapid progress is to be made either in the matter of surveys or in the examination and scientific study of mental deficiency, there must be a large increase in the number of those who possess the requisite qualifications."

The report, therefore, has a considerably wider application than its title would imply. Certainly every one interested in the problem of mental deficiency should be familiar with the opinions of the authorities so extensively quoted and with a state program of such practical excellence. The commissioner is to be congratulated upon the thoroughness with which the subject has been covered.

William C. Sandy.

Dwellers in the Vale of Siddem: A True Story of the Social Aspect of Feeblemindedness. By A. C. Rogers, M.D., and Maud A. Merrill. Boston: Richard G. Badger, 1919. 80 p.

Dr. Rogers, superintendent of the Minnesota School for the Feebleminded, whose death in 1917 ended a service of thirty-three years, had planned to publish in story form the family-history studies made at the school portraying the conditions found in the investigation of the homes of the children of the institution. Dr. Roger's death has made it impossible to carry out the original plan, but in partial fulfillment of the plan a series of studies is to be published of which the present book is the first.

The Vale of Siddem is the name given to a region in Minnesota where for several generations the descendants of a few families have lived and continued to intermarry. Studies were begun of the children in the institution coming from this region and continued in the region itself by collecting as much family and social data as was available. Even to one familiar with other regional studies the account is an astounding one and the following would not seem to be an overstatement:

"In these people of the hollow is 'humanity stript of its adventitious social trappings.' Exposed by the candid hand of Gorky, these 'ugly cancers of the social system' would not alone 'shame the evil,' but outrage the community. The complacent Americanism of us who regard with such patriotic superiority the evils of London slums and the pauperism and organized vice of an effete old world civilization! The commonwealth of Minnesota, young and vigorous, harbors already such nests of social incompetents, degenerates, defectives, and criminals as existed in the Jukes' ancestral mountain fastnesses. Mental deficiency is indigenous to the same soil that produces criminality, sex laxity, alcoholism, and pauperism. Whatever the relation of cause and effect in the matter, the sociological evidence is indisputable."

One could quote at random from the book to show the uniform condition of depravity found in the valley, but one chooses the following, as it illustrates another point as well:

"The parent Glades were a 'do-less' pair. The father was as little inclined to provide for his offspring as the mother was to utilize what was provided. On one occasion the clothes which had been furnished and made by some charitably inclined women from the town in the vicinity were found rain soaked and muddy back of the cabin, where the mother had thrown them rather than wash them. . . . The eleven children born of this union are all living except the two youngest. . . . With the exception of one, all of these children have functioned as feebleminded. . . . Five younger children, when the home was broken up, were committed to an institution whence two of them were later transferred to the Minnesota institution for the feebleminded. These two feebleminded sisters, Rita and Maggie, both pretty girls of the moron type, were taken, against the urgent protest of the superintendent, from the institution by a well-meaning relative, sponsored by a minister who promised to be responsible for them. The extent of that responsibility may be judged from the results.

"Rita is married. Her husband is Bill Hemp, the feebleminded son of Hank Hemp and a feebleminded woman. Hank was feebleminded. He and the woman cared for nothing except something to eat and a place to loaf. Bill has a feebleminded twin brother, also

married. Bill's former wife was a feebleminded prostitute, who, while living with Bill, gave birth to a feebleminded daughter who doesn't belong to Bill. This feebleminded daughter is now living with the son of old Rob Jincade, the counterfeiter of the ravine, a worthless, degenerate wretch. Bill had a feebleminded uncle whose wife died at the poor farm of the county a number of years ago. Danny, a son of this man, works around for the farmers in the neighborhood of the ravine, his labor bought with the promise of 'a nice woman for Danny.' It is Danny's one ambition to get married, but the women of the ravine won't have poor simple-minded Danny. This is Bill's family, citizen of Hog Hollow. When Bill married Rita, he took her home to live with his former wife and Rita 'got mad and left him.' She is now a prostitute.

"There is Maggie. For a while she worked in cheap restaurants. Then she married; not, however, a citizen of the hollow, but a feebleminded man like herself. On the night of her wedding, there was a family celebration. The groom and his friends became so intoxicated that they were dumped unconscious on the only bed the establishment furnished and the bride and her relatives slept on the littered floor."

The book contains valuable social data, but the maximum effect as a popular presentation, for which it was intended, is lost through careless writing and inadequate editing.

FRANKWOOD E. WILLIAMS.

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NOTES AND COMMENTS

Colorado

The State Home and Training School for Mental Defectives, located at Ridge, has received authorization from the legislature to establish an addition at the former Indian School at Grand Junction. The present buildings at Grand Junction will be repaired and improved and additional ones will be built later. An appropriation of $180,000 has been made for this branch, $30,000 to be used for furnishing and equipping the present buildings, and $150,000 for maintaining it during the years 1919 and 1920.

The bill to establish a psychopathic hospital at the University of Colorado, which was summarized in the January, 1919, number of MENTAL HYGIENE, was passed by the legislature, and approved by the governor on April 9, 1919.

Connecticut

The Connecticut State Hospital received from the 1919 legislature an appropriation of $175,000 for new construction, and $45,750 for additional fire protection. To the Norwich State Hospital was appropriated for additions and improvements $84,650. The Mansfield State Training School and Hospital received an appropriation of $12,500 for completion of buildings already in operation and $250,000 for additional construction, equipment, and improvements. This institution also shares a joint appropriation of $130,000 for water supply with the Connecticut Agricultural College.

An act approved May 8, 1919, authorizes the governor to appoint a commission to "investigate and report, with recommendations, to the next general assembly the advisability of segregating the defective delinquents, vicious feebleminded, and criminally insane in the state." This commission consists of a superintendent of one of the state hospitals for mental diseases, the superintendent of the school for feebleminded and epileptics, the superintendent or warden of a penal or correctional institution, a judge of the superior court, two members of the house of representatives, and one senator.

A law "concerning detention of violently insane persons" was enacted by the 1919 legislature of Connecticut. This law reads: "Any person who has suddenly become in need of care and treatment in a hospital for the insane may be confined in such hospital, either public or private, for not more than ten days without order of any

court. At the time of delivery of such person to such hospital, there shall be left in the hands of the person in charge thereof a certificate signed and sworn to by some reputable physician not more than three days prior thereto, stating that after a personal examination made not more than three days prior to the date of such certificate, he is of the opinion that the person therein named is in need of immediate treatment and the reasons therefor. . . . Except when otherwise provided by the general statutes, no person shall be committed or admitted to or detained in a hospital for the insane without an order of a court of probate, provided, when a person who has suddenly become clearly and violently insane is brought to such hospital, such person may be received and detained therein for not more than ten days without order of a court of probate, in accordance with the provisions of this act."

By legislative enactment, the name of the Connecticut State Hospital for the Insane has been changed to the Connecticut State Hospital, and the Norwich State Hospital for the Insane to the Norwich State Hospital.

Chapter 301, Laws of 1919, authorizes the transfer of minors from county temporary homes or reformatory institutions to the Mansfield State Training School and Hospital whenever the transfer shall be of benefit to the minor and he is a proper subject to be received at the latter institution.

A sterilization act was passed by the 1919 legislature of Connecticut. This law extends the provisions of the one enacted in 1909 so as to include the Mansfield State Training School and Hospital, which is the state institution for the care and training of feebleminded and epileptics. The purpose of the law is both eugenic and therapeutic.

Florida

By legislative enactment, the name of the Florida Hospital for the Insane has been changed to the Florida State Hospital. By the terms of another act, this hospital received an appropriation of over $200,000 for additional land, new buildings, and improvements.

Georgia

A state school for mental defectives was authorized by the 1919 legislature. The institution is to be known as the "Georgia Training School for Mental Defectives." A temporary board composed of the governor, the attorney general, and the secretary of the state board of health has charge of the establishment and location of the school. After its establishment, the school is to be under the direct manage-

ment of the state board of health. The superintendent must be a physician scientifically trained in psychiatry and with special training relating to mental deficiency.

The law provides for the admission to the school of the following types of persons: "Any person with mental defectiveness from birth or from an early age, or those that become mentally defective from injury or disease so pronounced that he or she is unable to care for himself or herself and manage his affairs with ordinary prudence, and that he constitutes a menace to the happiness of himself or of others in the community, and therefore requires care, supervision, and control, either for his own protection or for the protection of others, and yet who is not insane or of unsound mind." In case the institution is not able to accommodate all who are entitled to admission, preference is to be given to children and women of child-bearing age.

The law provides for court commitment upon the application of relatives or citizens of the county after an examination by two physicians with knowledge of and training in mental medicine. Admission is also authorized without court procedure, upon the application to the superintendent of the father, mother, or guardian of any mentally defective person, or upon the application of any health officer or school official in the county of his residence. This application must supply such data as the superintendent may require. In addition, an examination, both physical and mental, must be made by or under the direction of the superintendent.

In any court of the state where a prisoner is on trial for a misdemeanor and the judge has reason to believe him mentally defective, he may appoint two physicians to examine the prisoner to ascertain whether or not he is mentally defective. If the physicians pronounce him to be mentally defective, the judge may commit him to the Georgia Training School for Mental Defectives. In either of the cases mentioned above, the physicians must make a thorough mental and physical examination and must certify their findings.

A relative, guardian, or friend of any inmate of any state institution may appeal to the court placing him in said institution for an order from the court directing an examination of said inmate to determine whether or not he is mentally defective. If he is adjudged to be mentally defective, the court may commit him to the Georgia Training School for Mental Defectives.

"The training and treatment of those admitted to the Georgia Training School for Mental Defectives shall be along such educational, medical, and industrial lines as have proved effective in the most approved institutions for this type of persons."

The act provides for the parole and discharge, under such regulations "as may be scientifically promulgated by the state board of

health," of persons from this school, when in the judgment of the superintendent they shall no longer constitute a menace to themselves or others.

This act carries an appropriation of $100,000.

A Board of Public Welfare was created by the 1919 legislature. This board is composed of five members appointed by the governor. It is authorized to appoint a secretary, assistant secretary, and such other clerks as are necessary. The duties of the board are strictly visitorial and advisory. It is authorized to visit public and private institutions of an eleemosynary, charitable, correctional, or reformatory character, or which are for the care of the orphaned, defective, dependent, delinquent, or criminal classes. The board is to make reports on the condition of these institutions and the care of their inmates, efficiency of administration, etc. These reports are to be filed in the office of the board. It shall bring prosecutions for fraudulent solicitation or misappropriation of charitable funds and for gross neglect and mistreatment of inmates in institutions or in the care of agencies affected by this act.

All plans for new jails, reformatories, almshouses, and buildings for charity, supported by public funds or public collections, shall be submitted to this board.

The board must report to the governor annually the actual conditions and other pertinent matters, together with recommendations to be submitted to the legislature, and to the state board of health as often as once a month on matters subject to the jurisdiction of the latter board.

Whenever the governor considers it necessary to investigate any institution under the provisions of this act, he may direct this board or a committee of it to do so.

Kansas

The law for commitment of the feebleminded has been so amended by an act of the last legislature that, whenever no jury is demanded and there appears to the probate judge to be no occasion for impaneling a jury, or that trial by jury would be inexpedient, the probate judge shall appoint a commission of two qualified physicians, or one qualified physician and one clinical psychologist, to examine the person to determine whether or not he is feebleminded and to file with the court a written report of the result of their inquiries together with their conclusions and recommendations.

This law further provides that whenever in a court of record, during the hearing of any person charged with misdemeanor or crime, it shall be made to appear to the court that the person is feebleminded, the court shall remand such person to the probate court of the county for examination.

Chapter 298, Laws of 1919, changes the name of the State Home for Feebleminded, located at Winfield, to the State Training School.

Louisiana

A colony and training school for mental defectives was authorized by the last legislature of Louisiana. It is to be known as the "State Colony and Training School." Provision is made for both commitment and discharge by court procedure. Discharges may be granted for any of the following reasons: because the person adjudged to be feebleminded is not feebleminded; because he is so far improved as to be capable of caring for himself; or because relatives or friends are able and willing to supervise, control, care for, and support him and request his discharge.

The institution is to be under the general control and direction of a board of administrators, appointed by the governor. This board is to select the site, to have the power to erect the buildings, and to appoint a superintendent of the colony and school. The superintendent must be a graduate in medicine and especially fitted by training and experience for the duties of the position.

An appropriation of $25,000 is included in the law.

Montana

About $100,000 was appropriated by the last legislature for new construction and improvements at the state hospital for mental diseases. The sum of $50,000 was appropriated for new buildings at the school for feebleminded. Of these amounts, one half is available for the year ending March 1, 1920, and the remainder for the following year.

The 1919 legislature enacted a commitment law for the feebleminded and epileptics. This law provides for application to the district court by a parent, guardian, superintendent of a county hospital, any officer of the state bureau of child and animal protection, by the applicant in person, or by the superintendent of any of the state's institutions; a court hearing and an examination by two physicians. The president of the Montana Training School for Feebleminded, to which institution both the feebleminded and epileptics are committed, is authorized to prepare a course of study and to determine the training to be given, under the direction of the state board of education. This school is a department of the Montana School for the Deaf and Blind, located at Boulder. No inmate may be removed from this school, permanently or temporarily, except upon the written order of the superintendent or upon order of a district court of the state.

Oklahoma

By legislative enactment, the supervision of the Institute for the Feebleminded has been transferred from the state board of education to the state board of public affairs.

The East Oklahoma Hospital for Insane received from the 1919 legislature an appropriation of approximately $200,000, to be used for the construction of a ward building, a barn, a water plant and sewerage system, and for the purchase of 250 additional acres of land.

The Central Oklahoma Hospital for the Insane received $400,000 to be used for the following purposes: a building for disturbed women, one for white men, one for negro men, a laundry, refrigeration, and ice equipment, and for the completion and equipment of the electric light and the water system and general repairs.

Tennessee

A law enacted in 1915 creating a board of control to govern the penal, reformatory, and charitable institutions of Tennessee was repealed by the 1919 legislature.

West Virginia

A state institution for the care and treatment of colored mentally diseased and defective persons was authorized by the 1919 legislature of West Virginia. This institution is to be known as the State Colored Hospital for the Insane. The state board of control and a committee of three colored persons appointed by the governor are to select the site and provide plans for it. This hospital will admit negro residents of the state "who may be insane or mentally afflicted and such other incurable mental defectives as the state board of control shall deem eligible." The law also stipulates that all like persons of the negro race now cared for in other state institutions shall be transferred to this hospital as soon after its completion as practicable.

The general appropriation act of the state provides $150,000 for land and buildings, $75,000 for each of the years 1920 and 1921, and $15,000 additional for current expenses in 1921.

Wisconsin

The Central State Hospital for the Insane received from the 1919 legislature an appropriation of $100,000 for the construction of new buildings, half of which amount is to be available July 1, 1919, and the remainder July 1, 1920.

The Southern Wisconsin Home for Feebleminded received from the 1919 legislature an appropriation of over $650,000 for new buildings, equipment, furniture and furnishings, and improvements. Over $200,000 of this amount was to be available July 1, 1919, and the remainder July 1, 1920. This is a comparatively new institution for the feebleminded, having been opened February 14, 1919.

Chapter 533, Laws of 1919, which deals with commitment to homes for the feebleminded, states: "In cases of alleged feeblemindedness, the examination may be made by a clinical psychologist and a licensed physician skilled in mental diagnosis; but no person shall be recognized as a clinical psychologist unless he has received the doctorate degree in psychology, with work in neurology and psychiatry, and has had not less than two years of successful experience in clinical psychological work."

The National Committee for Mental Hygiene has been invited to make a survey of this state concerning the status of its feebleminded and epileptics. This invitation was extended in accordance with a joint resolution of the 1919 legislature of Wisconsin.

Eleventh Annual Meeting of the National Committee for Mental Hygiene

The Eleventh Annual Meeting of the National Committee for Mental Hygiene was held in the assembly room of the Russell Sage Foundation, 130 East Twenty-second Street, New York City, on the afternoon of February 4. The principal address was made by Dr. Thomas W. Salmon, Medical Director, who, owing to his service in France, had not been able to attend an annual meeting of the organization since the one held in 1917. Dr. Salmon spoke in part as follows, on *Lessons of the War and the Future Work of the National Committee:*

"There were three great lessons, I think, in mental hygiene which will profoundly influence the future work of the National Committee for Mental Hygiene.

"The first of these lessons is that there is no inherent reason why the cruel distinction between mental disease and general disease should continue to exist. For two years there was no such distinction for five million Americans serving in the army. If they continue to exist in time of peace, the reasons, not inherent in themselves, will depend on our attitude toward these disorders.

"The second is that by concerted action psychiatrists can collect human material for great tasks so that the fittest will be chosen for the severest stress and places of usefulness will be found for those who are only partially fit.

" The third lesson which I think the National Committee above all other organizations can learn from the war is that some nervous diseases, if attacked at their outset, can either be prevented or can be greatly modified in their duration, in their course, and in their outcome.

" To consider just for a moment the first of these lessons, in this city there are hospitals in every precinct. These hospitals represent the investment of millions of dollars, either public money or money given by those who desire to help their fellow beings. They are open for all classes of the sick; no distinction is made regarding color, creed or religion, age or sex. People with contagious diseases find provision in some of these hospitals; people, with no question asked as to their antecedents, as to whether they belong to the worthy poor or the so-called unworthy poor, are taken in—with one exception: in the catalogues of every one of these general hospitals in New York City you will find the words, ' Mental cases not accepted.' The catalogues do not go on to say where the mental cases should go. They simply announce in no uncertain terms that these great palaces erected for humanitarian purposes are not for diseases of the mind.

" In France the hospitals were not palaces. Some of them were located in schools and public buildings and were admirably suited to their purposes; others were in shacks such as we would be rather ashamed to have on the premises to house an automobile; and others still were in tents or ruined buildings near the front. But poor as these hospitals were, there was not one of them in which soldiers suffering from a disease of the mind were not as easily admitted and as fully welcome as those suffering from any other disease. It was not until these soldiers got back—after two years spent in a different kind of world, where sickness was all the same, whether it was mental or physical—that they found the distinction existing.

" Men who, in France, within six or eight miles of the line, were cared for in special hospitals or special wards of hospitals, with physicians and nurses who understood their diseases, are to-day to be found in jails and poorhouses because, when they got back to the United States, they found that that great lesson of the war had not been learned.

" So one duty of the National Committee is not simply to take this lesson of the war to heart itself, but to see that it is so disseminated throughout this country that that distinction will be wiped out in time of peace at home, just as much as it was wiped out in time of war three thousand miles away.

" The next lesson is that the examination of human material is a means of fitting workers for their places. It prevents those misfits

that cause great economic loss throughout the world and great unhappiness and inefficiency on the part of the individual. Seventy-two thousand men were excluded from the drafted army on account of mental and nervous diseases. The A. E. F., which represented the pick of the men selected finally for service, was probably a body the like of which has never been gathered together before. It was as free from defectives and psychopathic individuals as any group of men of that size could be.

" What were the actual results? Was the efficiency of the A. E. F. thus increased, and were its deficiencies lessened? In the army in 1915 there were just one hundred thousand men, and those one hundred thousand men, who were taken without very much attempt at selection, contributed during the year fifty-six suicides. The A. E. F. contributed, of its two million men in two years, ninety-four suicides. That is, had the suicide rate in the A. E. F. been the same as it was in the unselected regular army in 1915, there would have been 1,060 suicides. The insanity rate of the old army in 1915—a year spent entirely in peace—was three per thousand. That is, three men were discharged for mental disease for every thousand enlisted. The insanity rate in the A. E. F., where men were subjected to unprecedented stress, where many of the causes of mental disease which existed in the regular army in 1915 were very much accentuated, was one-sixteenth per one hundred thousand. That is, there was 40 per cent less insanity in the American army in France, engaged in active warfare during almost the entire period, than there was in the regular army in 1915, engaged in peace duties throughout the United States.

" One man in eight of the army in 1915 left the army before the expiration of a year through a criminal procedure, either desertion or a sentence of court-martial involving dishonorable discharge from the army. Had that rate prevailed in the A. E. F., two hundred and forty thousand of the two million who went overseas would have returned as prisoners, facing discharge from the army. As a matter of fact, the total number of men returned as general prisoners was 1,731. You must remember, too, that offences which are very slight in times of peace and are dealt with by summary measures are in time of war dealt with by general courts-martial and long sentences.

" So the examination conducted in the camps at home made their effects felt in the battlefields in France, and one of the duties of the National Committee is to impress this lesson upon the people for use in time of peace. Every year, out of the children who leave the public schools, we select several times the strength of the A. E. F. for all sorts of assorted tasks. Some of these tasks involve great stress and some of them involve very little. We make no effort at all to see that those who are unfit for those tasks are eliminated from the great

battle of life and those who are fit are given work well within their ability to perform.

" The other lesson, it seems to me, is that these nervous diseases which became the great military problem in time of war are susceptible of prevention and susceptible of cure if measures can be applied promptly. In France, with very great difficulties, many miles from home, where supplies were difficult to obtain, where personnel could not be at once replaced, but had to be brought over at the expense of fighting troops, it was possible to spare enough trained men to deal with the neuroses in the divisions and often in the smaller organizations. In field hospitals—the field hospitals nearest the line—attempts were made to sort the types of nervousness which developed in such enormous numbers, to treat those that were treatable, to prevent those that were preventable, and to see that no additional harm was done by wrong methods of management to those that had to be passed on to the rear.

" The result was that the problem of neuroses was a less important one in the combat troops, exposed to all the traditional effects of shell fire, than it was in the embarkation camps in the United States. The division produced fewer cases of neuroses which had to go to the rear and be treated in base hospitals or be evacuated to home territory than that same division produced while waiting for embarkation to France from ports in the United States.

" This is not simply an interesting observation of the war; it has a very direct bearing upon problems of civil life, because neuroses, which were called war neuroses in this country and shell shock at one time in England, are just as common at home as they are among soldiers. The schools and shops and any places where the burdens of life bear heavily upon human beings bring their crops of neuroses. The difference was that men were needed in the army and needed so badly that elaborate machinery could be devised to save them, while apparently it is not considered necessary to provide any such mechanism in time of peace.

" It is, I think, the duty of the National Committee to see that this lesson is well learned and is widely applied, so that the school clinic here in this country may represent the sorting field hospitals in France, and some type of preventorium, where nervous children may be taken and trained and cared for and treated, correspond to the army neurological hospitals, which turned back a brigade of infantry in the few weeks of fighting in the Argonne.

" So our war work of the National Committee cannot be abruptly dropped. It has to be carried on, both to impress the lessons learned and to continue the care of the soldiers themselves. The task of caring for soldiers discharged with mental disease lies upon the United

States Public Health Service. This service finds already, only a year after it assumed the task, that 38 per cent of all the cases requiring hospital treatment are mental cases; that no other medical problem, not even that of tuberculosis, is so important among discharged soldiers as the care of mental diseases. To meet this need the Public Health Service plans to establish from eight to ten new psychiatric hospitals in various parts of the United States, where every effort can be made to restore those cases that are capable of recovery and to ease the lot of those for whom recovery is impossible.

" The National Committee finds that it bears very much the same relation to the Public Health Service in this work as it did to the army in 1917. The Public Health Service had some difficulties in making its plans, in fixing its ideas as to the kind of treatment to be given, and, above all, in finding the personnel of trained men and women to carry this treatment on. The National Committee, through its longer experience and through its national outlook in these matters and its large acquaintanceship with personnel, has been able to supply some of the needs in just the way that it did in the early days of the war, when the army suddenly found itself confronting the problem of caring for a large number of mental cases.

"Another factor has to be reckoned with in the mental cases among discharged soldiers which does not exist in any other class of sickness. and that is that of all the patients who need care, these are the only ones who don't know it. The mental cases are not applying for treatment, demanding it as their right. In many cases they are evading it, and even their families do not realize the necessity of getting skilled care for them. So, with mental cases, it is necessary to go into the home, follow up discharged soldiers who are unemployed or who are having social difficulties, and find out whether those difficulties are due to mental disorder.

" This requires a system of psychiatric social work broad enough to include all parts of the country and connected with clinics, so that it can be guided by the expert medical care required. Through special funds the National Committee has been able to do a great deal in this field. It has already supplied trained psychiatric social workers in five different important centers. It has aided a good deal in stimulating the Red Cross to provide such workers in other places and it has induced the Public Health Service to make psychiatric social work a definite and integral part of its campaign.

" So the bridge between the work of the National Committee in the past few years and its work in the next few years is a continuation of activities which came out of the war. It has been decided that it would be unwise to continue a special committee for this purpose. After all, advancing the care of mental disease is the prime purpose

of the National Committee for Mental Hygiene, and that applies quite as much to men who have been soldiers and who are now civilians as to the wives, mothers, and daughters of these soldiers, who have always been civilians.

" Of course, the war work constitutes the bridge between the recent past and the first tasks to be assumed, now that we have all got back to work and reorganized ourselves for our general work. Still, this opportunity for a fresh start has been taken advantage of in many different ways. We have asked ourselves quite seriously—not only the executive officers, but the members of the executive committee—whether we should continue on just the same lines that we were following when the war interrupted all our work. Shall we begin where we left off, or shall we take advantage of this fresh start to drop certain things that have perhaps not been as important as we thought they were and substitute new activities which are likely to be more important and more productive and more popular?

" In answering this question, the first subject that we have to consider is our work on behalf of the insane. Why should we devote so much of our energy, or perhaps any of our energy, to improving the condition of the insane who now are excluded from the benefits of treatment? Why not accept that condition as a deplorable fact, one quite beyond our control, one that originated in another generation and is simply a legacy of the present?

" I think the reasons for continuing that work are pretty strong. In the first place, our own self-respect demands it. I don't think we could go around and preach mental hygiene and the care of people who are not really ill, but who are going to be, and forget that in more than half the states many of those who are suffering from severe mental disease are to be found in jails and almshouses. To do so would cause ourselves a good deal of uneasiness, and I think in the end would cause a certain amount of public lack of confidence and bring a certain amount of discredit upon the organized work itself.

"A report just received from an important Middle-Western state shows that in 1919 there were 1,060 insane persons cared for in jails, and some of these people had been in jails since 1914. All but six counties in that state—a state not, like some of the Southern states, pressed by the enormous problem of negro population and having very small resources, but rich, prosperous, and in a healthy condition in every way—cared for a thousand sick persons in jails without any special question being raised in the minds of any one. It seems to me that as long as these things exist, the National Committee has no choice but to continue its vigorous efforts of popular education in creating a better sentiment, so that such things will be impossible in the future.

" Nevertheless, the feeling has been developing that we ought to approach even this task in a more fundamental way. The value of our state surveys in the care of the insane has been very great. Nobody questions those surveys being carried on at the present time, and they will be carried on in future just as actively as funds permit. Still, we have been feeling more and more certain that the method is getting at the wrong end of the problem; that any such surveys should be accompanied by some pretty definite efforts to prevent the conditions at their source. The very root of the matter is the training of physicians. Every one of those places in states where conditions are bad which have been described at preceding meetings of this committee was visited regularly by doctors, who attended to the sick, so-called, and who thought that the condition of the insane was no affair of theirs. It is true to-day that the graduates of medical schools who will go out in 1920 are no better prepared to recognize or to deal with mental disease than their predecessors who graduated twenty years ago. So no very lasting reform, no very essential change in the treatment of mental diseases, will occur until physicians generally are better educated in these matters and have something of the same standards in the care of mental illness that they have in the care of general illness.

" For this reason the committee feels that its work for 1920 should be, to quite an extent, in the medical schools, that our work of popular education has gone on very far. The popular attitude toward these things, I think, has quite changed in some communities during the last ten years. The medical attitude is practically unchanged and our task now is not so much to educate the layman in medical matters, but to educate the doctors in medical matters, and one of our most important pieces of work during the year to come will be just this.

" The education of doctors without clinical material, of course, is nothing but preaching. It is impossible to train physicians to recognize mild and border-land types of mental disease except with rich clinical material, and this is best provided for in the university psychiatric clinic. The committee has, therefore, decided during the year to make a drive on this particular subject, to try to build up public support of the university psychiatric clinic, and to try to secure from one source and another some substantial financial aid to those dozen universities which to-day are willing to establish university psychiatric clinics as soon as reasonable expectation of support is assured.

" Before the war the committee made its first demonstration in the application of psychiatry to criminology in the clinic at Sing Sing prison. That clinic was interrupted by the war, when it had to be abandoned and its director went into the army. We feel that this study of the psychopathology of crime is one of the most promising

openings, that without any hesitation at all we should continue to expand and develop our work in that line.

" We have a better machine to work with than we had when the war broke out. We have now—as we didn't have then—departmental organization. The organization up to 1917 was a pretty primitive form. It consisted of two or three executive officers and a certain number of highly trained lay assistants. Now it has been felt that our work is important enough to be divided up into certain departments—that mental deficiency and its problems are important enough to take the full time of one associate medical director with such assistants as he requires; that the work of popular education, which is perhaps the most important single duty of the National Committee for Mental Hygiene, is important enough to require one full-time associate medical director.

" So we are beginning the next year with a different type of organization, with our organization broken up into departments, each with its share of the budget. Now the budget itself, we learn from the report of the Finance Committee, is pretty small. Only about $70,000 could be appropriated for the entire year's work with justification when we think of the means at hand. We must remember that the shrinkage of the dollar has made this amount of money equal to only about $50,000 in 1916 and 1917. Still, we are fortunate in having the continued support of the Rockefeller Foundation in carrying on our field work. The field work in the form of surveys and demonstrations does not cost the National Committee anything from its general budget.

" So we begin the year with all our personnel back from the war, with the great impetus given us by the psychiatric lessons of the war, by the increase in importance of mental and nervous diseases in the public eye as a result of their wide prevalence in the army, and with a better type of organization, one that will be very much more effective in carrying out this work. We should like to begin it with a little more money, but I think none of the executive officers feels discouraged with the budget if that amount can be secured during the next few months."

Brief remarks were made by the two associate medical directors, Dr. Williams and Dr. Anderson; the secretary, Mr. Beers; Dr. Walter E. Fernald, Chairman of the Committee on Mental Deficiency; Dr. C. Macfie Campbell, Chairman of the Committee on Education; Dr. Charles F. Martin, President of the Canadian National Committee for Mental Hygiene; Dr. C. M. Hincks, Associate Medical Director and Secretary of the Canadian Committee; and Dr. A. H. Desloges, a member of that organization.

The following officers were elected:

Officers: President, Dr. Walter B. James; Vice-presidents, Dr. Charles W. Eliot, Dr. Bernard Sachs, Dr. William H. Welch; Treasurer, Otto T. Bannard.

Executive Officers: Medical Director, Dr. Thomas W. Salmon; Associate Medical Directors, Dr. Frankwood E. Williams, Dr. V. V. Anderson; Secretary, Clifford W. Beers.

Executive Committee: Chairman, Dr. William L. Russell; Dr. George Blumer, Dr. Owen Copp, Stephen P. Duggan, Dr. Walter E. Fernald, Matthew C. Fleming, Dr. Walter B. James, Dr. George H. Kirby.

Finance Committee: Chairman, Dr. Walter B. James; Otto T. Bannard, Professor Russell H. Chittenden, Dr. William B. Coley, Professor Stephen P. Duggan, William J. Hoggson.

Committee on Mental Deficiency: Chairman, Dr. Walter E. Fernald; Dr. L. Pierce Clark, Miss Elizabeth E. Farrell, Dr. Charles S. Little, Honorable Harry V. Osborn, Honorable Herbert C. Parsons, Professor John B. Watson.

Committee on Education: Chairman, Dr. C. Macfie Campbell; Dr. George Blumer, Professor Stephen P. Duggan, Dr. Walter E. Fernald, Dr. Stewart Paton, Professor William H. Burnham, Dr. Robert M. Yerkes.

A resolution on the death of Dr. August Hoch was adopted. This is given in full on pages 434-35.

Third Convention of Societies for Mental Hygiene

The Third Convention of Societies for Mental Hygiene was held at the Waldorf-Astoria and the New York Academy of Medicine, New York City, February 4-6, under the auspices of the National Committee for Mental Hygiene in coöperation with the Mental Hygiene Committee of the State Charities Aid Association. Delegates were present from Canada, Maine, Massachusetts, Connecticut, New York, Maryland, Pennsylvania, Indiana, Illinois, Kansas, and the District of Columbia. There were three public meetings; at one of these Miss Julia C. Lathrop, Chief of the Children's Bureau, Washington, presided, and at another Major General Merritte W. Ireland, Surgeon General of the United States Army. The following papers were read: *Trade Unionism and Temperament; Notes on the Psychiatric Point of View in Industry,* by E. E. Southard, M.D., Director, Massachusetts Psychiatric Institute, Boston; *Psychiatry in Medical Schools,* by Thomas W. Salmon, M.D., Medical Director, The National Committee for Mental Hygiene, New York City; *The Psychology of Infancy,* by John B. Watson, Ph.D., Johns Hopkins University, Baltimore; *The*

Experiences of the Child; How They Affect Character and Behavior, by C. Macfie Campbell, M.D., The Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore; *Program of Mental Hygiene in the Public Schools,* by E. Stanley Abbot, M.D., Medical Director, Mental Hygiene Committee, Public Charities Association of Pennsylvania, Philadelphia; *Childhood: The Golden Period for Mental Hygiene,* by William A. White, M.D., Superintendent, St. Elizabeths Hospital, Washington, D.C.; *Applicability of the Neuropsychiatric Examinations in the Army to Civil Problems,* by Pearce Bailey, M.D., Chairman, New York State Commission on Mental Defectives; *Some Mental Hygiene Lessons of the War,* by Thomas W. Salmon, M.D.

In addition to the public meetings, there were round-table discussions by the delegates of problems of immediate importance in organized mental hygiene work. The subjects taken up were: Financing Societies for Mental Hygiene, Problems in Connection with the Establishment of Community Clinics, Relative Values in Methods of Publicity, Problems of Legislation, State Society Problems Relative to Discharged Soldiers, Planning and Organizing Conferences.

Canadian Bulletin of Mental Hygiene

The Canadian National Committee for Mental Hygiene has issued the first number of a *Bulletin of Mental Hygiene,* an attractive twelve-page leaflet filled with items of current news pertaining to the progress of mental hygiene in Canada and the activities of the Committee. The *Bulletin* is to be published quarterly and in addition to the *Journal of Mental Hygiene,* which will begin its second volume in April.

A Survey of New Brunswick

In November the Government of New Brunswick, through Dr. W. F. Roberts, Minister of Health, requested the Canadian National Committee for Mental Hygiene to make a survey of the province. This will be the first study of its kind to be conducted in Eastern Canada. This forward step, together with recent health progress, in New Brunswick, has been made possible largely through the creation in 1918 of the Ministry of Health—the first in Canada. The work of Dr. Roberts' department is wide in scope and includes not only matters relating to the public health proper, but to inspection of schools, factories, foods, lodging and boarding houses, the registration of births, marriages, and deaths, and the inspection of cattle, horses, and other classes of live stock.

A Medico-Psychological Association for Ontario

At a recent conference of the medical superintendents of Ontario hospitals and others engaged in the study of mental diseases, a medico-

psychological association has been formed, with Dr. E. Ryan, Professor of Psychiatry in Queen's University, as president, and Dr. J. M. Forster, of the Ontario Hospital, as secretary. It is intended that this association shall become affiliated with the Medico-Psychological Association of Great Britain.

Research in Occupational Therapy

Through the generosity and understanding of a friend of occupational therapy, it has become possible to establish at Marblehead, Massachusetts, a small experiment station for the study of the problems of invalid occupation. The plan is to maintain a studio and workshop where designers and craftsmen, unhampered by the demands of teaching, may work out ideas and suggestions for hospital industries.

The general value of regulated work in convalescence and in long continued disability is firmly enough established. But the time is coming soon when those who are directing this branch of medicine will be called upon to prescribe with increasing accuracy, and when the work of patients will have to be standardized and improved in design and quality. The sponsors of this experimental shop are interested in all phases of occupational therapy, but specially in the development of new occupations which will be elastic enough to meet the varied requirements of invalids and which will at the same time result in really valuable products.

There will be a small permanent staff of designers and craftsmen and probably a rotating staff of occupational aids who can leave their active teaching long enough to work out their own problems under favorable conditions.

The new shop is devoted wholly to the advancement of occupational therapy. Any profits which may come from the sale of tested materials or of finished products will be turned into the plant or used toward scholarships for visiting teachers.

It would seem as though there were very definite use for such a center, but if the new venture is to have full value and effectiveness, it must secure the coöperation of every one interested in occupations for invalids.

Teachers and others are invited to send in ideas and suggestions which will be studied and developed whenever possible, and which if used will be publicly acknowledged. Address all correspondence to Herbert J. Hall, M.D., Director, 69 Pleasant St., Marblehead, Massachusetts.

A New Publication for Psychiatric Social Workers

The Social Syndrome, the new publication of the Alumnae Association of the Smith College Training School for Social Work, made its

first appearance in February, 1920. The purpose of the paper as stated by the editors is as follows:

" We realized the tendency that students in any profession have, after leaving their places of training, of failing to refresh themselves by contacts with their fellow workers. Operating as single agents in new localities, they lose the opportunities of stimulating competition and debate.

" The *Syndrome* has, then, as the first object of existence to furnish a means for containing contacts with the various members of the group. It is to mobilize the group experiences for the good of each individual.

" In a world so new and mobile as that of mental hygiene, where one event takes place on the heels of another, there is need for many vehicles for interchange of plans and purposes. Again, in a profession so new as that of psychiatric social work, inspiration is not easily drawn from casual contacts. There is no fund of accumulated wisdom to draw upon. To a degree we must be textbooks for each other.

" The second object of existence is to keep before us a larger contact, that of a wider range of human endeavor, applied sociology in its broadest sense. We are, of course, only a part of a movement. This paper aims, instead of accentuating our group consciousness, to help us to become assimilated into general social work. We are going to try to keep in touch with various other movements, parallel in interest to ours, and to call attention to new departures in our own province.

" The third and last object of existence is more narrowly to carry on the work of the Smith College Training School for Psychiatric Social Work. We believe in it. We want to carry on to others the spirit and enthusiasm which the summer school engendered in us. We want to recruit new members to become a part of its widening purpose. We want to keep personally in touch with the present and future of the school and to interest ourselves in all the details that will make for progress and betterment. We will keep up our contact with the school! . . .

" We realize that each succeeding issue will have to be a combination composed by different personalities of new and original material with never the same identity of factors behind it. Yet we want to keep alive the same group of ideas by real contact with each other and to stimulate others to an interest in our work. A syndrome is ' a group of symptoms occurring together.' Therefore we present ourselves—*The Social Syndrome.*"

The first number contains short articles by directors of the school, graduates at work in various parts of the country, and others, with alumnae notes and items of interest in the field of psychiatric social work.

The courses offered by the training school in 1920-21 are announced in the school bulletin, which also appeared recently. They include a course in social psychology, in mental tests, in child psychology, in theory of social case work, in government as a factor in social work, in social psychiatry, and in social medicine. In all of its courses the school emphasizes the psychological approach to social problems. The division of the work into eight weeks of theoretical instruction combined with clinical observation, followed by nine months of practical instruction carried on in coöperation with hospitals and settlements, and a concluding eight weeks of advanced study, is, in the opinion of the sponsors of the school, the best method for this type of training. It is their belief that " practice work with social cases and social conditions cannot be carried on satisfactorily with intensive instruction, since it is not possible to regulate human problems so that experience will run parallel with theoretical instruction. There is great value for drill and discipline as well as depth of experience in the uninterrupted practice and in the continuity of theoretical study which the present plan provides."

The summer courses are open to workers of approved experience and to teachers of approved standing. A few scholarships are offered for the benefit of meritorious students who could not otherwise afford to attend the summer sessions. Application for these should be made before May 1. Also, some interneships in hospitals are available for students in the practice course in psychiatric social work upon application to Miss Mary Jarrett, Associate Director.

Graduates of the school are filling responsible positions in social-service departments of hospitals, with the Red Cross and the New York Charities Aid Association, with state committees for mental hygiene and charity organization societies. The salaries received in such positions by graduates of the class of 1919 range from $1,000 to $1,900 a year.

The Individual as a Unit in Case Work

As social case analyst, I find myself somewhat at variance with many social workers, doubtless because I cannot entirely remove myself from the prejudices of my medical profession. Every time the social worker shows me her card catalogue of families, I find myself as physician revolting somewhat therefrom and clamoring for the separate members of the family. Practically always, we find, I think, one figure, or at least two figures, dominating the family scene as causes of the maladjustment in question. It is either some sick person demanding special care, or perhaps it is some ill-trained parent who can hardly be made to understand the situation; or else there is

some legal entanglement which has the family by the heels without special responsibility to be laid to more than one or two of its members. In short, when a case of social maladjustment comes seriously before us, do we not want to get at the separate and distributive points of each individual in the family situation? Shall we ever succeed in social adjustment by any plan which treats the members of the family as virtually interchangeable and as all subject to some one economic, legal, moral, or intellectual régime? Accordingly, as a preliminary to the orderly approach to the analysis of social case data, I would propose (subject to the limitations of a social-service proposition made by a physician) that the analysis be applied to the separate members of a family, separately and individually, so that the point of view of each family member may get its due. In fine, I would be personally inclined to abolish the family as a unit of interest in social service and to replace that unit with the individual. E. E. Southard, M.D.: *The Kingdom of Evil: Advantages of an Orderly Approach in Social Case Analysis.*

Psychiatry in Medical Education

At the Annual Congress on Medical Education and Licensure held in Chicago in March, Dr. Ray Lyman Wilbur, President of the Leland Stanford Junior University, is reported by the *Journal of the American Medical Association* to have said:

"We put tens of thousands of the mentally sick into great isolated institutions, largely without medical students or training schools for nurses. Through competent administrators we care for them reasonably well, but we have learned and are learning but little of mental disease. The ignorance of the average medical man of psychology and psychiatry is painful. Every such hospital should be a live, optimistic center for study, and not a pen for the lingering care of the hopeless or semi-hopeless. We cannot think of medical education in the future without bringing the stimulus of the student to all such hospitals, and likewise bringing one such hospital into the closest of contact with every university medical school. Perhaps with the establishment of such conditions we can gradually place the decisions on the questions of mental conditions in the hands of physicians instead of in those of untrained judges and emotional juries."

The General Practitioner

The dominant figure in mental hygiene must be the physician in general practice. The family physician first sees the incipient mental and nervous conditions of abnormal character or tendency. He must

afford, or guide to, their earliest recognition and treatment. He is the adviser in the rearing and education of children and their choice of vocation and life environment. His insight may discern mental factors in family, social, industrial, and governmental problems and his enlightened understanding of their significance may inform, mold public opinion and stimulate legislative action according to progressive and wise policies.

The public and the legislature have the right, as well as the inclination in the last resort, to appeal to the physician for direction in such matters. No greater responsibility and professional obligation devolve upon him than the acquisition of such knowledge and the taking of such personal interest that he may discharge them with wisdom and effect.

He may feel the lack of instruction and clinical training in mental and nervous disorders in his student days. This sense of deficiency should be expressed to his alma mater with insistence that teaching in mental and nervous disorders shall become as adequate relatively as in surgery and internal medicine.

He will be perplexed, perhaps disheartened, in providing suitable hospital treatment and nursing for his indigent mental patients, especially during the transfer from home to hospital care; often may not be able to keep them out of the hands of the police and jail during the interval, possibly at a critical stage of illness. He must use his strongest and most persistent influence with the local general hospital to make provision for such temporary care and treatment and their continuance to recovery of many mental and nervous conditions which may thus escape the insane hospital.

He should take an interest in promoting community service to mental patients by the support of a mental clinic and other agencies of social work in their behalf in his vicinity.

He will be astonished at the insufficiency of accommodation and equipment for hospital treatment and study of the great mass of indigent patients who crowd into our public institutions for this class. His sympathetic understanding, his influence with local officials, his coöperation with the hospital management, his appeal to the legislature in support of sufficient appropriations will achieve much in carrying out a progressive state policy in this important matter.

These are the obvious duties of the individual physician in his own community, but, as an organized body, the physicians of the state should have a definite policy and controlling influence in all health and disease problems, both mental and physical.—Owen Copp, M.D., The Duty of the State and the Physician to the Mental Patient, *The Pennsylvania Medical Journal*, December, 1919.

Ex-Officers of the Medical Corps Appointed or Commissioned in the Public Health Service

The following ex-officers of the Medical Corps of the army have been appointed or commissioned to positions in the Reserve Corps of the United States Public Health Service:

To U. S. P. H. S. Hospital No. 1, Baltimore, Maryland, Henry E. St. Antoine as Past Assistant Surgeon;

To U. S. P. H. S. Hospital No. 21, Stapleton, Staten Island, George M. Melvin as Past Assistant Surgeon;

To U. S. P. H. S. Hospital No. 26, Greensville, South Carolina, C. R. Miller as Past Assistant Surgeon;

To U. S. P. H. S. Hospital No. 28, Dansville, New York, Melvin J. Taylor as Surgeon, Donald L. Ross as Surgeon;

To U. S. P. H. S. Hospital No. 29, Philadelphia, Pennsylvania, O. C. Willhite as Senior Surgeon;

To U. S. P. H. S. Hospital No. 37, Waukesha, Wisconsin, Thomas J. Heldt as Acting Assistant Surgeon; Isaac Frisch;

To U. S. P. H. S. Hospital No. 40, Cape May, New Jersey, Nicholas Pinto as Past Assistant Surgeon; Frank M. Hallock as Past Assistant Surgeon; Edwin P. Bledsoe as Surgeon; Baron Ross Nairns;

To U. S. P. H. S. Hospital No. 44, West Roxbury, Massachusetts, Ord Everman as Acting Assistant Surgeon; A. P. Chronquest as Senior Surgeon;

To the Bureau of War Risk Insurance, New York City, Francis M. Shockley, George C. Fisk, Allen D. Finlayson;

To the Vocational Board, New York City, Eugene M. Boudreau, John J. Harrington;

To the Mental Survey, Oregon, C. L. Carlisle as Acting Assistant Surgeon;

To New Orleans, Louisiana, Edmond McC. Connely as Acting Assistant Surgeon;

To Augusta, Georgia, Frank E. Leslie as Senior Surgeon, commanding officer of hospital.

A. S. Pendleton has been commissioned as Senior Surgeon.

The Mental Condition Preceding Suicide

Editorial, *The Journal of the American Medical Association*

It is a curious, but well substantiated fact, commented on some time ago in *The Journal*,[1] that there are fashions in suicide just as there are in almost every other human activity. Indeed, the fashion changes

[1] The Style in Suicide and Homicide, Current Comment, J. A. M. A. 73: 1367, November 1, 1919.

not only with regard to the methods employed for terminating existence, but also in the whole attitude of peoples toward suicide. In the days of the ancients, suicide was not regarded as a crime. The Stoic school of philosophy taught that every person had the right to decide whether or not to continue in this life.

In the United States alone about 10,000 person annually terminate their existence by self-destruction. This large number of deaths naturally brings up the question of the prevention of suicide, which in turn leads to a consideration of its causes. Since self-destruction is no longer countenanced by public opinion, the number of suicides has decreased considerably, and it is safe to assume that persons seldom resort to the procedure unless they are mentally abnormal or unless there are strong reasons of an unpleasant nature. Certain psychiatrists—Forbes Winslow, for example—have held that invariably persons who commit suicide are mentally abnormal; but there is little doubt that this view is not correct. In the case of criminals, particularly, there is evidence of deliberate suicide by persons perfectly capable of understanding the nature of the act. The fact remains, however, that in existing circumstances the majority of those who take their own lives are mentally abnormal. Recently Brend,[2] in discussing the mental condition preceding suicide, has shown that probably 50 per cent of all such persons are definitely insane, and that most of these are suffering from melancholia, chronic alcoholic insanity, or the hebephrenic form of dementia praecox. The statistics from certain European army hospitals indicate that patients suffering from psychoses, particularly those of the manic-depressive type, are much more likely to commit suicide than patients suffering from neuroses. Neurotic persons frequently discuss suicide and express fear that they will do away with themselves, but they hardly ever reach the point of actually attempting self-destruction. Figures quoted by Brend show that among 3,700 patients suffering with neuroses there were only one suicide and two unsuccessful attempts, whereas among 3,000 patients suffering from psychoses there were three successful suicides and 105 unsuccessful attempts. It is tolerably clear, therefore, that a considerable proportion of all suicides occur in mentally abnormal persons.

The question of the prevention of suicide is intimately associated with the early detection and treatment of insanity. At present, agencies for the early detection and treatment of insanity are conspicuous chiefly by their absence. This is true not merely in the United States, but throughout the world. Some progess has been made in com-

[2] Brend, W. A.: The Mental Condition Preceding Suicide, *Practitioner* 103; 1401, December, 1919.

bating this condition by the establishment of psychopathic hospitals and by the educational efforts of bodies like the National Committee for Mental Hygiene and its allied state committees; but material progress will not be made until the public has been educated to a more acute appreciation of the importance of the early detection of mental disease, and until the facilities for the early treatment of mental cases under voluntary commitment to a hospital for the insane have been widely extended. It is quite certain that more widespread education in mental hygiene would result in a reduction in the number of suicides.

After-Care Plan for Mental Patients

At the Conference on Mental Clinics and Social Work held at Ward's Island, New York City, Dr. Mortimer W. Raynor, clinical director of the Manhattan State Hospital, outlined as follows the after-care procedure at the Manhattan Hospital:

All patients under consideration for parole are either presented to one of the staff conferences devoted each week to that purpose, or the case is considered in conference with the superintendent or clinical director. A short abstract of the essential facts, including antisocial tendencies, is made, together with the plans of the patient's friends. The social worker attends the parole staff meetings and investigates all doubtful cases. The abstract and recommendations of the conference, together with the social worker's report when requested, are submitted to the superintendent. As soon as he approves, the copy with the approval is returned to the physician in charge of the patient and another copy is given to the social worker, who sees that it is filed at the proper clinic. When the patient is paroled, he is instructed, and it is entered on his parole card, to report at a certain clinic on a certain day. One copy of the parole card is given to the social worker, who files it at the clinic according to the date the patient is requested to report. Therefore the clinic physician has before him the abstract of the patient's record and the cards of the patients who are to report on that day. When the patient reports, proper notes are made of his condition, and the date of his next visit is entered on his card, the clinic card being filed according to the new date. If the patient fails to report, he is written to and advised to report at the next clinic day. If at that time he fails to report, the social worker makes an investigation. It has been thought advisable to leave to the clinic physician the matter of determining in each individual case the date of each visit to the clinic subsequent to the first visit. Of course all patients are advised to report at any time they are in need of advice. Practically all our patients are paroled for six months. Each patient is requested to report to the clinic at least two weeks before the expiration of his parole. At that time the clinic physician closes the clinic record and makes recommendations as to the extension of the parole or the discharge of the patient and, if the latter, the condition on discharge. This is then forwarded to the ward physician in time to take whatever action is necessary. If the parole is to be extended, the patient is notified to report again at a specified date.

It is impracticable to ask certain of our patients to report at clinics, especially the sick and infirm and those going out of the city. These cases report monthly by letter and are looked after by the social worker. I might add further that

afternoon and evening clinics are held, the latter for those patients who are employed; also that the social worker attends all clinics and interviews all patients. With the above plan in operation, the number of patients on parole has increased from 145 patients in 1916, to 325 in 1917, 429 in 1918, and 990 in 1919, with a daily average in the last year of 464. During the past year 477 patients reported at the clinics with a total of 1,998 visits.

Children Versus Foxes

In a certain section of Canada the breeding of foxes constitutes a thriving industry. A humble student of mental hygiene happened to be visiting in the neighborhood. He trudged along and finally came to a cross-road where he discovered a public school on one side and a fox ranch on the other. He noted that the school was in a dilapidated condition and housed fifty children. The teacher was an amiable individual, who found it possible to preserve good nature and to keep body and soul together on a salary of $300 per year. A visit to the fox ranch across the road proved much more stimulating. The caretaker was a prosperous individual who received remuneration to the extent of $2,000 per annum. It appeared that fox ranching was given a higher place in the estimation of the community than the training of children.

A conversation with the caretaker revealed the fact that he was a keen student of mental hygiene, and at his own suggestion he took the visitor to a wired enclosure in which there was a mentally deficient fox. When questioned as to whether he intended using this specimen for breeding purposes, he held up his hand in protest and said that if he followed such a policy, his industry would be ruined.

One could not help but compare these two organizations—the fox ranch and the school. The school teacher was poorly paid, while the caretaker of the fox ranch received a living wage. The latter adopted scientific principles, while the former attempted to ignore the presence of mentally defective children, and, indeed, allowed them to pass out of her hands into the general community, where they would procreate their kind.

Is Canada wise in continuing a policy in which live stock are placed at a premium while children are neglected?—*Mental Hygiene Bulletin*, The Canadian National Committee for Mental Hygiene.

Results of Treatment in Neurosyphilis

In February, 1916, Dr. Harry C. Solomon of the Boston Psychopathic Hospital reported in the *Bulletin* of the Massachusetts State Board of Insanity a series of ten cases of neurosyphilis—eight diagnosed as general paralysis and two as cerebrospinal syphilis—showing favorable results obtained by treatment. In the *Boston Medical*

and Surgical Journal for January 15, 1920, Doctor Solomon reports the condition of these patients after four years. Doctor Solomon's conclusions are as follows:

"A review four years or more after the dismissal from the hospital of ten cases of neurosyphilis who were reported as aided by antisyphilitic treatment is made. Nine of these patients were committed as insane, the remaining case was diagnosed general paralysis, but not necessarily commitable. Eight cases were diagnosed general paralysis, two as cerebrospinal syphilis. It should be added that the diagnosis of cerebrospinal syphilis was changed from general paralysis on one of these two only because he cleared up under antispecific treatment. The mental symptoms were those of paresis. Of the eight cases diagnosed general paralysis, five are now living at home. Three are apparently entirely well; two, while not well, are able to care for themselves and live a normal life in the community. Two are dead and one is in a hospital. One of the two who died had a fair remission with economic efficiency for eighteen months and had all laboratory reactions negative at one time. The one who was in a hospital had a remission of three years duration. Two cases were diagnosed cerebrospinal syphilis (nonparetic), but with marked mental symptoms. One left hospital apparently entirely normal and with negative laboratory signs. He has been lost from view. The other is now serologically negative and mentally normal after four years.

"Of eight cases diagnosed general paralysis, three are apparently entirely well after four years; two are well enough to live outside and care for themselves; one had remission of more than three years' duration, now in hospital; two are dead, having had remissions of eighteen months each.

"Of two cases diagnosed cerebrospinal syphilis with mental symptoms, one is lost from observation, the other is mentally normal and serologically negative.

"This report leads the author to feel that it is possible to help a portion of cases of general paralysis or cerebrospinal syphilis with mental symptoms and that intensive, systematic treatment will change the prognosis of general paralysis. It was not the intention to discuss the percentage of cases of general paralysis that could be helped when this report was first made in 1916, but it did represent a fair percentage of the cases that had had intensive treatment. At this time the desire is merely to bring this report up to date. It does seem encouraging, however, that the results have been so good for such a relatively long period. We conclude that the majority of cases of syphilis of the nervous system, whether the so-called cerebrospinal syphilis, tabes dorsalis, general paralysis, or other forms, are entitled to treatment, and if this is done thoroughly, intensively, and system-

atically the results will be gratifying. The form of treatment, mercury, iodide, arsenic intraspinous and intracranial injections, and the amounts will necessarily depend upon the condition of each individual patient."

STATEMENT

As Required by the Act of August 24, 1912

OF THE OWNERSHIP, MANAGEMENT, ETC., OF MENTAL HYGIENE

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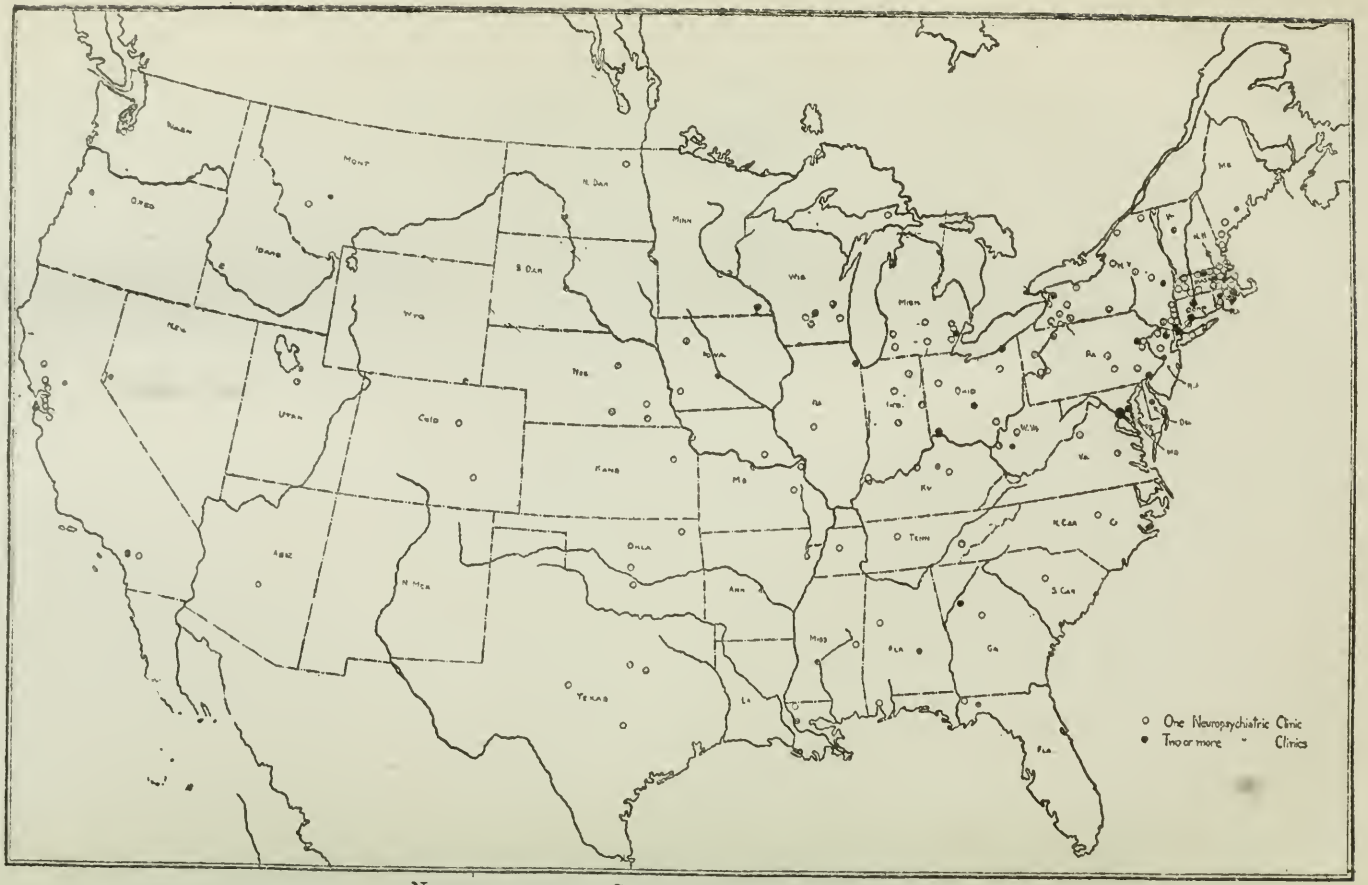

NEUROPSYCHIATRIC CLINICS IN THE UNITED STATES

A map showing the geographical location of nervous and mental clinics in the United States, prepared from a list recently published by the National Committee for Mental Hygiene

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MENTAL HYGIENE

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THE MINIMUM OF MEDICAL INSIGHT REQUIRED BY SOCIAL WORKERS WITH DELINQUENTS*

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IT is a good thing for the cobbler to stick to his last, and it is well for the physician not to give advice on matters outside of his province. It is useful, however, to pool our knowledge, so that workers in different fields may avail themselves of results gathered from different sources. The scientist studying the phenomena of life in his laboratory may come across facts that revolutionize the moving-picture industry. So the cobbler, interested in his fellow men and women, and noting the disparity between the shoes he cobbles and the natural shape of the human foot, may do well to leave his last for a few moments and put his facts before tortured humanity.

The physician is in the same position as the cobbler, and feels that he is bound occasionally to leave the hospital and the laboratory to put before a more general audience some of the results gained in his special field.

To understand the interest of the medical worker in the problems of delinquency, it is well to be clear as to the rôle of the physician in general. For some a physician is a man who treats symptoms; he finds dry coughs and moist coughs, stomach aches and headaches, biliousness and dropsy, and for each he hands out a suitable pill, powder, or potion. For others the physician is a man who treats not symptoms, but diseases;

* Read before the Mental Hygiene Division of the National Conference of Social Work, New Orleans, April 20, 1920.

he discovers these dread diseases by means of cunning laboratory tests and elaborate apparatus, and then routs them by means of antitoxins and other therapy, qualified by a variety of prefixes.

It is better to think of the physician as a man whose business it is to treat, not symptoms or diseases, but sick people. It is true that the physician can often relieve symptoms with appropriate drugs, and that he often receives precise guidance in treatment from laboratory tests; but it is also true that in many cases, even after he has X-rayed every segment of the patient and analysed all the juices that can be extracted from him, the physician is puzzled until he remembers that he has overlooked one factor—the patient. The patient is more than a group of symptoms, more than a collection of interesting juices; he is a living individual with a most complicated pattern of reactions, and the physician who overlooks this pattern may find the symptoms intractable, the disease unintelligible. Headache may be a reaction to eye strain, but it may be a reaction to a mother-in-law; pain in the back is sometimes explained by an X-ray plate, but sometimes by unwillingness to work; indigestion may be more closely related to a troubled conscience than to poor cooking; palpitation is not always an indication of organic heart disease—it may be the expression of the romance of life gone astray. Not that the situation is always simple; the patient with organic heart trouble may have romantic longings; a bad cook may conspire with a troubled conscience to ruin the digestion.

The extent to which a man is disabled depends partly on the nature of his disease, but perhaps more on the way he reacts to it. Trudeau, tuberculous, withdraws to the Adirondacks to establish the scientific treatment of tuberculosis; R. L. Stevenson continues his literary labors to the last; Helen Keller astounds the world by her demonstration of what personality can do to overcome physical handicaps.

Not symptoms, not diseases, but sick and handicapped people are what the physician has to deal with. He has to study man's ways of getting along in the face of the tests of life, and if the failure in one case show itself by a convulsion, in another by a theft, the analysis of the factors involved to a large extent follows the same lines. It is in both cases a prob-

lem of human conduct, and a study of the underlying forces. Human conduct is the reaction of the individual to the environment; that reaction depends on the condition of the bodily organs and systems, on factors such as fatigue, sleeplessness, pain, etc., on the constitutional equipment of the individual, and on its modification by previous experiences. Each man has his own innate endowment—intellectual, emotional, dynamic—and the reaction of to-day is determined in part by the reactions of all the series of yesterdays. In face of the same situation different men behave differently; danger threatens, one man faints, another is struck dumb, a third is paralyzed, a fourth trembles violently. To some are given at birth stout hearts; some have always stomach for a fight, others are continually weak-kneed.

The social worker who would understand delinquent acts must be familiar with the unequal endowment of different individuals, with their differences in intelligence, their differences in emotional response, their differences in sources of energy. Such familiarity involves knowledge of the machinery at work in human reactions—that is, knowledge of the nervous system with its receptive, elaborating, and emissive departments; it involves some knowledge of the sources of energy within the human body and of the specific importance of certain glands. The influence on the total behavior of the individual of flaws and crudities in several parts of the mechanism, the influence of faulty sense organs, of poorly elaborating or poorly retentive or poorly inhibiting brain tissue, of clumsiness or weakness in the motor department, of deficient or excessive secretions of glands, of poor food, poor clothing, poor ventilation, of stimulants and smoking, of insufficient sleep, and of fatigue must be known. These facts must be known not only in general terms, but must be sufficiently familiar from a careful study of actual cases for the worker to be alert to their possible influence in the case of the individual delinquent reaction that she is studying. The worker must have sufficient personal contact with cases where malnutrition, physical weakness, pain, or fatigue has seriously reduced the ability of the individual to resist the impulses of the moment; she must have studied cases where the disorder of a gland has led to apparent laziness, truancy, bad compan-

ionship, and delinquency; she must have carefully studied in concrete cases the bearing of eye strain, deafness, or other physical incapacity upon a chronic latent feeling of discontent and revolt, leading to an overt delinquent act; she must have some familiarity with cases of dishonesty or sexual misdemeanor determined by early senile changes in the brain or by incipient general paralysis.

The social worker cannot be expected to have a complete medical grasp of the above physiological and pathological facts; but she must be sufficiently familiar with them to realize the importance of a thorough medical examination of the delinquent, sufficiently familiar with them for her whole attitude towards the problem to be modified by this background. She does not need to know the details of medical classification, nor need she be able to handle medical jargon fluently; she should, however, be sufficiently familiar with medical terms to be able to use medical reports, even though couched in technical terms.

Not only are the above simple medical facts required in the study of human behavior; there are other facts with regard to the springs of human action with which the physician is specially familiar, in the light of his knowledge of the neuroses and psychoses. The general public has heard much of war neuroses, and is to a certain extent familiar with the fact that the war neurosis, whether it show itself in an apparent blindness or paralysis or tremor or stammering, results from the conflict between the various conflicting forces of human nature, between the instinctive tendency to withdraw from danger and seek safety and the tendency to stand by one's group and carry out one's social duty. There is no essential difference between the nervous disorders of war and those of peace, only the conflicts of peace time are less obvious; in the ordinary disorders of peace time it needs painstaking study to find out before what difficulty in the home or the social life the patient is shrinking. In such an examination complete honesty is demanded from the patient, and only in the consulting room does one have the opportunity of studying human behavior with the conventional trappings and disguises removed. In the conventional behavior of daily intercourse, in the drawing room and the market place, we habitually talk and

act falsehoods; we are always glad to see one another, the deceptive social smile becomes developed in our teens, we are properly shocked at the tabooed, we go into mass rapture over what is officially endorsed. If there is little frankness in the drawing-room, there is still less encouragement to be frank in the dock. It was not possible to understand the war neuroses of the soldiers, nor is it possible to understand the neuroses of everyday life, without studying the conflicting instincts, the emotional problems, the painful memories of the patient, and the same principles at the basis of the study of the neuroses have to be applied to the study of the delinquent episode or career. It was easy to call the war neurotic a malingerer; it is easy to call the peace neurotic a wilful weakling; it is easy to call the delinquent immoral. The aim of the social worker is not to be content with these easy terms, but to be really sensitive to the problems involved, to wonder about the why of the individual act, to know something of the subtle underlying forces. The study of the neuroses has thrown a flood of light on the hidden springs of human action. The social worker with delinquents must be familiar with the general principles of this branch of medicine. She must know something of the mechanism of hysterical symptoms, of morbid fears, of lapses of memory, of the feeling of inferiority and methods of compensation, of repression of painful memories and inferior tendencies towards action, of the substitutive expression of repressed forces, of compulsive acts and thoughts at which the patient himself is perplexed, of the development of fads, infatuations, antagonisms. The worker must also have some insight into the mechanism of those more serious cases in which the patient, unable to get satisfaction out of the real world, withdraws into a world of fancy, peopled with the creatures of his wishes and fears, and with an atmosphere seen through which the happenings of the real world become sadly distorted; she must have some insight into the reasons for the development of a twisted view of the world, of ideas of being under strange influences, of morbid suspicion, hate, love, and egoistical expansion.

Familiarity with these facts, which are the product of the labor of the consulting room, is necessary, not merely because the worker will have at times to deal with those mentally un-

sound, but in order that she may understand human behavior in general, the behavior of normal individuals, of the people she meets at dinner and at church, as well as of people whom she meets because they have committed a delinquent act. It is well to remember that delinquency is a relative conception, that an act is delinquent because it conflicts with the standards of a majority of the community at a certain period.

The social worker has, therefore, to consider the delinquent act in the setting of the environment, as the physician has to study in detail the true inwardness of the situation in which the patient has developed a neurosis. The physician, in dealing with a nervous patient, may find that the patient has broken down because he has had to react to an environment that was itself unhealthy and needed modification; it is sometimes the situation and not the patient that requires treatment. So in the study of the delinquent act the situation has to be kept in mind. Truancy may be the reaction of a subnormal boy to a healthy school situation, but it may be the reaction of a healthy boy to a subnormal school situation; street baseball may happen to be considered a delinquent act, but it may be the manifestation of a sick police or community organization rather than of disordered conduct in the players. To be in jail is not necessarily a disgrace; it may be merely a mistake—I do not refer to mistakes of the police, but to a mistaken attitude of the person in jail; it may in rare instances be a virtue.

The physician dealing with nervous and mental patients is hampered by the cruel tradition that makes an absolute separation between certain groups of patients. It is most unfortunate that this tradition is even embodied in the terms that are used. We "admit" patients to "hospitals"; why, then, do we talk of "confining" other patients in "institutions"? It will take some time before the tradition is overcome, before the community feels towards all sick people in the same way, realizes that the mentally sick are not absolutely different from the ordinary run of humanity. Just as the term insanity has a rather paralyzing influence on our thought and blinds us to the fact that there is no abrupt transition from the modes of thought of the sane to those of the insane, so the word delinquency is apt to have the same

paralyzing effect. It is difficult to shake off its rigid implications, to remember that a delinquent act is an act delinquent at such a time and in such a place, that from truancy to murder in the first degree there are all varieties of delinquency. To say that one is "not at home" when seated comfortably in one's own sitting room is not looked upon with severe disapproval; to try to establish a false alibi under less conventional circumstances may have painful consequences. To steal a dollar frankly from a man in the street is a delinquency, while to relieve him of thousands through the technique of high finance arouses the spirit of emulation. Let us keep in mind that delinquency may be the delinquency, not of the individual, but of the society.

To summarize briefly, the social worker with delinquents must have insight into the fact that all men are not born equal and be familiar with the different inequalities of intelligence, of output of energy, of emotional stability, of physical vitality, of special sense organs, of bodily systems.

She must have insight into the manifestations of inferiority in these different spheres in childhood, adolescence, maturity, senescence, must be familiar with the whole field of mental defect and of mental and nervous instability.

She must know something of the effect on conduct of insufficient food or sleep, of pain, fatigue, bad air, alcohol, and other poisons; she must have some insight into the complexity of the instinctive and the emotional life and of the total personality.

She must have some insight into the puzzling outcroppings, in the form of nervous or delinquent acts, of underlying turmoil in the emotional life, must be familiar with the common nervous disorders of childhood and the neuroses of adults.

She must have some insight into the influence on the personality of the early attachments of the home, must realize how early experiences and situations dominate later behavior, must have some grasp of the general factors that determine the formation of habits.

While the above covers to a certain extent the topics in which the physician feels he can be of use to the social worker with delinquents, I would emphasize above all that it is the attitude of the worker that is important, and that the worker

should cling tenaciously to accurate observation and easily intelligible formulation. Let the worker with her scientific ambition not forget the following A B C:

Avoid jargon.

Be sensitive to the atypical, always curious as to causes.

Cultivate common sense.

INDIVIDUAL VARIATIONS IN MENTAL EQUIPMENT*

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IN social work, as in all fields of constructive activity, a fundamental need is knowledge of the nature of the material dealt with. In the sciences interest lies mainly in determining the qualities and characteristics of a given material or organism, the laws to which it is subject, the purposes to which it is adapted. The arts, conforming to the facts that science has determined, are concerned with achieving certain ends. Social work, like art, aims at accomplishing ends; it is primarily concerned with treatment. But this treatment should be in conformity with the facts that science discloses. That the material is human and hence highly complex and variable makes this necessity not less, but infinitely greater. In contrast to other simpler material in which the qualities are comparatively fewer and more limited in their modifiability, human beings are very impressionable, changeable, plastic, capable of alteration and development far beyond any other material with which work is done—and yet, meriting study the most, the human being is generally studied the least.

In order to deal intelligently and rationally with human beings, obviously there must be acquaintance with certain practical aspects of that most important science of human life —psychology. Social work as it has developed in the past has been focused specifically on all sorts of conditions and facts that make up the setting of its human problems, while more or less neglecting essentials of the qualities and possibilities of the human beings themselves. Psychology, on the other hand, until very recently has been least interested in the settings, the external conditions, even as they most vitally affect mental life; it has dealt exclusively with the generic nature of mental life in human beings, apart from action in life, apart from the interplay between diverse human nature and diverse

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environments. This state of affairs, however, has somewhat changed, and already, in the last decade or two, there has been accumulated a body of scientific psychological fact which is available for those who would be effective students of social processes. It is clear, in particular, that the social worker should know much of the psychology of individual differences and of the factors that are active in producing varieties of human beings and varieties of behavior.

With knowledge of so much of applied psychology as belongs to this field, a vastly better approach can be made to the specific problems of particular individuals. No matter what the problem may be, one essential consideration is the determination of the individual's mental make-up or equipment. Maladjustments or failures—educational, vocational, economic, or otherwise social—can be understood only in the light of the mental equipment of the individual. And by equipment we mean innate abilities and traits as they have been modified by training and experience into habits and tendencies of thought and action, and particularly as they still offer potentialities for further modifications.

Of course, even the most materialistic considerations of social work, physical or economic, have been recognized to some extent as dependent on mental life, at least by some workers; but until recently it has been felt that intuition or ordinary opinion or common-sense judgment sufficed for the evaluation of the mental equipment or potentialities of the individuals involved in the situation. No systematic or carefully planned inquiry formed part of the investigatory scheme of the social worker.

Nowadays psychological and psychiatric study of the individual is fairly well accepted in principle, even where no opportunities for such study exist. There is, however, a tendency, far too widespread, to accept the view that adequate study can be made by a brief, more or less formal examination, and that the giving of some test or scale is the only thing that is needed to answer all one's queries or guide all future efforts. The attitude of the lay worker—and sometimes, unfortunately, of the professional worker as well—is indicated in a questionnaire sent out the other day by a national organization, which sums up the facts desired on mentality as

follows: "If the person has been examined, state if pronounced feebleminded or insane. If not examined, give your impressions of the mentality." This point of view is, of course, ridiculous. A moment's common-sense reflection will lead to the realization that mental life is so complex and that the practical issues are so numerous that any brief examination or any short, summary statement of the mental equipment must necessarily be incomplete and must overlook points of great significance for practical adjustment.

A lesson that we have been forced to learn well, as we have attempted to meet the practical social issues of the cases presented to us for opinion, is that adequate study of the mental make-up or equipment must cover at least five aspects. These we shall take up and briefly outline, not in the order of their importance, for that is hard to determine and varies with the individual. But since it is most commonly discussed and uncritically asked for and interpreted by the social worker at present, we may well begin with the age-level rating of mentality.

I. Age Level Tests

Testing by an age-level scale, such as the Stanford revision of the Binet—the scale perhaps most widely used at the present time—has certain advantages: (1) it is a method in very common use and hence admits of ready comparative studies; (2) it estimates so-called "intelligence" or "general ability," not emphasizing any one ability; (3) it enables one to classify in terms of mental age or intelligence quotients (the I. Q.). Thus Terman—and, indeed, Binet and each of the revisers of the scale—has stated that, according to the score obtained on the scale, the individual shall be diagnosed as supernormal, normal, dull normal, border line, or feebleminded.

Although we do not agree that such a classification should be based on an age-level scale alone, and despite its limitations and inadequacies, yet it is undoubtedly true that such testing gives a rough placing, a first blocking-out of some of the problems that need to be corroborated or studied further.

The Binet scale and its revisions do not suffice alone for a number of reasons. (1) The results are not always reliable, for they are influenced by special abilities and disabilities;

thus a good or poor auditory memory span raises or lowers the score unduly. (2) Educational and cultural opportunities play a large part in success or failure on some of the tests. The scale involves language very largely, and the final score is markedly affected by the chances one has had to acquire a certain vocabulary and to gain facility in the understanding and the use of language. (3) Special abilities and disabilities that may be matters of great practical import are left totally or largely unrevealed. The scale deals almost entirely with ability to deal with ideas, and gives no hint, for example, of ability to deal with things, as we have long insisted, and with persons, as Wells has pointed out. (4) The final score may be readily misinterpreted, especially by those untrained in clinical psychology; the mental age or I. Q. given out as the only necessary statement, implying that from it all facts about mental equipment can be inferred, gives rise to numerous misconceptions.

Practically, just what does the mental age or I. Q. mean? Suppose, for example, the result shows that a young woman of twenty has a mental age of twelve years or an I. Q. of 75. How shall one interpret this? Surely no one believes that, for purposes of social treatment, this is any answer to the practical questions that arise. Does one believe that this young woman of twenty, with eight more years of world experience than she had when she was chronologically twelve years old, can be considered as in all ways comparable to, much less exactly like, a child of twelve? And yet, as if this were true, there is nowadays a great clamor by the uncritical for this type of bare numerical statement, as if all could be told in a word or a couple of digits. Even among children of twelve years there are vast differences in make-up and potentialities. Does the statement, "I. Q. 75," mean anything very helpful without many more supplementary data? We have, as a matter of fact, only a very slight notion of the practical correlations, such as social adjustments, that any ordinary I. Q. indicates.

The above points might be illustrated by numerous examples, varying in details. We may group these under three headings:

(a) Cases in which the I. Q. is unreliable because too high.

Here, for example, is a lad about eleven years old. His intelligence quotient on the Stanford scale is 117, which grades him as considerably supernormal. A very wide range of other tests gives results greatly at variance with this. On several he scores at age; a large number of others grade him from slightly below age to three years retarded. On not a single test other than the Stanford is the score above age. In the light of this, shall one still call him supernormal? How shall we interpret his high I. Q.? Analysis of the separate results of the scale shows that the score is influenced by remarkable auditory powers which enable him to receive credit for successes at twelve, fourteen, and eighteen years. A highly specialized ability thus distorts the picture that the final score gives. If we used age-level tests alone and made inferences only from those, our social treatment in this case would in all likelihood be a failure.

(b) Cases in which the I. Q. is unreliable because too low. An instance of this kind is the case of a boy of fourteen and one-half whose I. Q.—80—would classify him as being subnormal or dull normal. But on many tests—arithmetic, motor control, visualizing powers, apperceptions, and particularly in working with concrete material—he made good records. On some of these his performance was far above the normal for his age or school grade. His particular disability was concerned with language; although he was born in this country and attended the public schools, he had much difficulty with both the use and the comprehension of language. In the light of all the tests that he passed so well, many of them being of much social importance, we were convinced that his proper classification should be normal, of at least fair ability.

(c) Cases in which the I. Q. does not reveal the significant features of mental ability. Irregularities in performance are sometimes the outstanding fact of a mental examination; this may itself be due to any one of several different causes, such as physical conditions—epilepsy notably—or to prolonged indulgence in debilitating habits, or to some sensory defect. The irregularity may or may not be indicated on the age scale; in case it is, the extent cannot be determined without supplementary tests. Thus, a boy of fourteen, just entering high school, was seen as a vocational and educational problem, the

question on the part of a relief agency being whether his abilities warranted further assistance to the family so that the boy could continue in school or whether it would be wiser to start him at work. If the latter seemed advisable, for what occupation was he best adapted? His I. Q. was 93, grading him as average normal. Other tests showed much more that was important; they varied in score from nine-year norms to those for superior adults. None of the causes mentioned above were operative, and tests for various types of performance were consistent with one another. Language ability was found very poor, as was ability to deal with concrete material, but auditory powers were very good, and facility with numbers was clearly evinced. The boy seemed incapable of profiting by further high-school instruction, but was apparently well fitted for special training as a bookkeeper. This conclusion would scarcely have been justified, or even possible of attainment, on the basis of age-level tests alone. This case suggests our second consideration in the study of individuals.

II. Study of Special Abilities and Disabilities

Besides estimating general ability, it is advisable to know as much as we can about the special abilities or disabilities of those for whom a constructive program is under consideration. From the practical standpoint, this is important, for it cannot be too frequently emphasized that greater values are likely to accrue from grading the individual *up* rather than grading him down. Since study of mental equipment is most valuable as a basis for constructive efforts, we wish to know all that we can of the potentialities that promise the greatest likelihood of successful development and use, which augur best as a means of contributing to the individual's happiness and usefulness and to society's welfare. Hence we are interested in revealing the abilities that can be utilized educationally, vocationally, and socially.

One of the more recent directions in which educational and applied psychology has been moving has been toward devising and standardizing trade and vocational tests, by means of which qualifications for specialized tasks shall be measured. This is entirely in keeping with our own point of view and

seems justified both from common-sense and from scientific considerations.

The cases already cited give some indication of the facts that we have in mind. The range of special abilities found is quite large, and we cannot illustrate all the types here. The most commonly thought of is mechanical ability. We have heard or read quite a bit in educational discussions of the child who is "hand-minded" rather than "book-minded," of those adapted for vocational and pre-vocational classes rather than for academic courses. This ability to deal with things rather than ideas, with concrete material rather than abstract, is not tapped at all in the age scales. For vocational purposes, such ability should be thought of as divided into three kinds: (a) simple manual dexterity—that is; ability to use the hands skilfully and quickly; (b) mechanical skill, where, besides dexterity, there is ability to deal with problems presented in concrete material; (3) planfulness, resource, and originality in dealing with concrete material.

The first of these is exemplified in unskilled factory work, such as packing or pasting, where speed is the primary need. The second may be illustrated by repair work, where parts of a machine, let us say, must be put together. The last is typified by the inventor or the mechanical engineer, where originality is the great desideratum.

We often see instances of special ability of the first or second kind and occasionally of the third; the following cases will illustrate:

A young woman of seventeen recently studied did poorly on most tests; she was classified as subnormal. She had, however, remarkable speed and dexterity in the use of her hands, grading far above the average in this, but she could scarcely solve construction tests requiring judgment as to the relationship of pieces to one another. Clearly she was fitted only for routine factory work in which speed was the greatest requirement. A lad almost fourteen years old, grading as average in general ability, made just about an average performance on tests for a number of abilities. On tests for manual dexterity he did well, but on those for mechanical ability where planfulness and insight were required, he made remarkable records—indeed, on a half-dozen such tests he rapidly made

perfect scores. This demonstrated ability was later corroborated by very successful work in the shoe shop of a correctional institution. Unfortunately, his marked special ability was not taken into account in the adjustments made still later. The boy was paroled on a farm where he had no outlets for his skill along mechanical lines and where, in consequence, this skill was not only wasted, but the lad was dissatisfied and unhappy as well.

Other special abilities are equally helpful signs which, if properly read, guide vocational advice and action. Sometimes the discovery of special ability in the field of language, together with certain personal qualifications, has led us to recommend training in salesmanship. Special ability in clerical work can be fairly reliably determined by the tests now available. Again, good visualizing powers may offer the basis of educational and vocational advice. Recently we studied for vocational guidance a young woman, seventeen years old, who was taking a commercial course in high school with very slight success. She had already failed in the academic course and had transferred to the business course as the only alternative. Psychological testing showed the unsuitability of this; in the clerical examination she ranked among the lowest 2 per cent. But the study demonstrated unusual ability in powers of visualization. On the basis of this, we recommended training in draftsmanship. This advice was followed, and our last report stated that she is happier and more successful than she has been at any time since she entered the high school.

The reverse of this—the discovery of special disability—should of course be equally as practical a determinant in educational and vocational efforts. Obviously it is unwise, uneconomical, and productive of poor results to train or place people at work for which they are innately unfitted. The round peg and the square hole are frequently enough spoken of, but the relationship is not always recognized when it appears. Nor is the situation avoided as frequently as it might be and probably would be if special inaptitudes were known. Only too commonly, employment that is available is the criterion of adjustment, and, no consideration being given to its suitability, much less scientific knowledge of fitness, the

outcome is likely to be a speedy need for a new job for the applicant. We have known of bright boys and girls who were placed at routine work not at all worthy of their capacities, and work unsuited to abilities is often assigned when the chance for success is slight. We know a young fellow of sixteen who, committed to a correctional institution, spent two years in the carpentry shop, though our mental examination disclosed a considerable disability along that line. Another boy was permitted to enter the commercial course in a high school when his ability for arithmetic was notably poor, whereas his fine capacity for arts and crafts was totally unrecognized.

Thus the discovery of special ability or disability of social significance enables one to direct education and vocation and, by aiding in a definite program, makes the prognosis in problem cases much more favorable and the recommendations for treatment much more specific.

III. Functioning of the Mind—The Dynamic Aspect

When "mental abilities" have been ascertained, there still remains the question how well, with these abilities, does the mind function. What is the individual's mental working ability? How great is the capacity for output? Perhaps we can best present this problem of dynamics by giving two contrasting illustrations.

A lad, fourteen years old, was recently studied by us at great length. He was a boy who had had many opportunities—he had traveled, lived in a home of culture, attended a private school that bears a fine reputation. Although encouraged in every usual way, he remained at the very foot of his class, not successful in any of his studies. He had had tutoring and yet, although well-behaved and amenable, he made poor progress. The results on the age scale gave no aid in understanding the difficulty; he graded as supernormal—I. Q. 113. On many other tests he did very well, especially where directions were to be followed. He also passed the vocabulary test for superior adult intelligence. Yet on a word-building test, in which six assigned letters are to be combined into words, he reached only a nine-year norm. He was steady, but slow in reactions. While willing enough, he was not at all

alert or keen mentally; on a number of tests he showed little initiative, resource, or imagination. He showed no special disability; no physical defect offered the explanation. He was not only lacking in energy in mental tasks, but was reported as not responding to any competitive stimulus, was not interested in athletics or in anything that required exertion. Both his family and teachers regarded him as intelligent, in spite of his failures, social and in the classroom. With us his high I. Q. and the exceedingly good results on some other tests indicated that there was no lack of ability; we were led to conclude that this was distinctly a problem of mental dynamics.

It is a far cry from this last case to the notable instance of a feebleminded girl, twelve years old, who was in the sixth grade. Our impressions, dictated at the end of the examination, read, "Very lively, responsive girl. Tremendously energetic. Works with tests in most remarkable fashion, so that she gets every bit of which she is capable out of herself. Her dynamic qualities are very striking. Her great energy and application to a task have no doubt aided her much in her school progress." A year later we learned that she was in the seventh grade.

The facts relating to mental energy, to powers of continuity of purpose and effort, all belong to this present category. Here, too, we must place the problems of those constitutionally inferior persons who, though not rating as defective mentally, yet are lacking in forcefulness and effectiveness whenever a situation becomes at all difficult. Here also belong questions of mental balance and control, which so largely affect the actual accomplishment, no matter what the innate capacity may be. There are problems of individuals over-dynamic, impulsive, hyperactive, perhaps even defective in control, and of the intelligent people who do not adjust well because oversensitive and thus unduly inhibited.

The first of these is illustrated in the case of a young girl, fourteen and one-half years old, who, placed out by an agency, was found a great problem in each of several homes. Immediately upon seeing her, one was impressed by her general attitude. She was strong, sturdy, alert, vivacious, rather a tomboy in manner, over-active physically. From her reactions while with us, from her social history, from her own

statement of her interests and desires, it was clear that she was of a strong, distinctive personality. She was impulsive and uncontrolled to the extent of being practically defective in inhibitions, was changeable in ideas and purposes, uncritical, generous, unrepressed, and childish. She described herself as bold and defiant; she was reported stubborn and self-willed. She was fond of outdoor sports and the most active recreations. Mentally she was normal, and it was evident that the problem was not one of capacity, but rather one of balance and control.

The problem of the over-inhibited is well known. Typically, the case is that of a bright, conscientious girl with an excellent school record who is unsuccessful socially or vocationally because of her timidity, sensitiveness, and lack of self-confidence.

IV. Personality Make-Up

In the study of mental equipment there must be a place for the sizing-up of personality. Although at the present time there are available no standardized tests analogous to mental tests, psychiatrists have emphasized the need for such study and some schedules have been outlined for the characterization of individuals. We have long appreciated the importance of including personality studies, and our tendency is more and more to inquire and observe and to formulate specific descriptive terms. That it is possible to do more than this at present we doubt, even though we regard with interest certain attempts to estimate by a numerical value these character traits. Subjective standards and interpretations offer the only means of evaluating these objective and highly important life reactions.

Practically, it is often difficult to determine what is innate personality make-up and what is the result of environment and experience. The interplay of the two is great, and the innate make-up can scarcely be distinguished from the product of circumstances. Perhaps, from one point of view, such separation is not needed or desirable, and yet, for the offering of prognoses, it is sometimes essential to know just what the individual is innately and what he might be like under different circumstances. Thus, we saw a girl, only nine years

old, who was a most difficult placing problem. Everywhere she lived there were complaints of violent behavior, temper spells, quarreling, and rough treatment of children. She was a most unpleasant personality, regarded as disagreeable by foster mothers, teachers, and playmates. The major point at issue when we studied her was determination of the extent to which her personality might be modified by some therapeutic endeavor, which in turn seemed to depend on the question as to whether her traits were innate or the result of experiences. In the course of the study, previously unknown causative experiences were unearthed, and with these brought to light and special social and educational processes undertaken, there has been a marked change in what before were called personality traits.

It is true, conversely, that the same experience reacts differently on different individuals. Thus two brothers, a year apart in age, both bright, were subjected to the same experience. The one was markedly disturbed thereby, the other apparently totally unaffected. This variance in effect is possibly due to differences in personality make-up, while, in turn, the experience itself may change the personality, at least for the time being, as in the case of the one brother who became very peculiar and irritable, so that he was regarded by all as a specific personality problem. Very frequently cases are met where the personality is reported as distinctly changed, and study reveals that this has followed upon some peculiar specific experience.

The personality make-up may be the feature of a case upon which all the adjustments are conditioned. Practical procedure sometimes is more largely determined by this than by any aspect of mental ability. Thus, for example, the social treatment of even the mentally defective may be considered in terms of the personality characteristics shown. One feeble-minded lad is socially suggestible to a marked degree, though perhaps industrious and mild; under good supervision, where suggestible to good influences, he may succeed in a simple environment. Another, with an identical I. Q., is aggressive, a leader, possibly even vicious; he needs, perhaps, segregation. The social adjustments here are not determined by mental capacity, but very largely by character and personality traits.

V. Mental Content

Lastly we come to the group of problems which we may designate as those of mental content, an aspect of mental life often overlooked by the psychologist, just as the study of general ability and of special abilities and disabilities is usually neglected by the psychiatrist. To understand the fundamentals of conduct, one must inquire into and be acquainted with the stuff of which the individual's mental life is woven. What forms the content of his mental life? What are his interests, his ideals and ambitions? In what fancies or phantasies does he indulge? What ideation is more or less recurrent? Does he have daydreams, and of what do they consist? Is he subject to obsessive thoughts or imagery?

In general, we are accustomed to consider the mental content as good or bad, but as a matter of fact, the problem is sometimes concerned, not with good or bad content or ideation, but with mental emptiness—vacuity. The surprising fact, according to our experience, is that, notwithstanding compulsory school education and the abundance of social settlements, community centers, and other similar organizations, there yet may be found many persons of decidedly good ability who have almost no mental interests and the paucity of whose mental life is amazingly meager. It is astonishing to discover, for instance, the number of young people who know nothing of everyday affairs in the midst of which they live—who are unaware of the resources of their city, who have no interest in clubs, books, politics, art, music, or indeed in any ordinary wholesome activities or recreations. Of course this may sometimes betoken lack of ambition, but frequently it is not a matter of dynamics—the individual has plenty of energy for other things.

For instance, a young girl, sixteen and one-half years old, was found to be quite bright; her I. Q. was 107, which indicates that she was somewhat above adult intelligence according to the Terman scale. She was very quick in her reactions, and on a wide range of tests she did well without exception. She had graduated from grammar school at fourteen, third highest in her class. After a prolonged study—for she was seriously delinquent—we stated, "The most interesting feat-

ures of her make-up are lack of curiosity and narrow range of interests. She seems never to have thought deeply about anything. She says of herself that, when eight years old, she read a book or two by Alger and has never read a book since, does not read newspapers or magazines, never read a novel." She had gone to no lectures; she knew nothing of social or civic affairs; having been asked to join the Red Cross, she had made a small money contribution, but had taken no active part. She went very occasionally to dances and rarely to the theater. She had no curiosity even about sexual matters—never wondered or asked about such things. When she became acquainted, in the waiting room of a department store, with a young woman who later introduced her to a group of other women, she had no curiosity about them or their lives, even when after a short time they led her into shoplifting. She said of herself that in school she learned easily—that usually after reading a history lesson, for example, she could recite it verbatim.

Such unfortunate mental vacuity can be only a little less pernicious than definitely bad mental content. What specific ideation or imagery may be harmful to the individual, or to society through the individual, it is, of course, impossible here to discuss in detail. The most disturbing mental content no doubt centers about sex matters, with the sometimes ensuing misconduct, irritability, dissatisfactions, deleterious physical and mental habits, repressions, or mental conflicts. Or the flow of mental life may be most unfortunately given over in considerable measure to ideation concerning stealing or gambling or other misconduct or to undesirable notions of adventure. Ideas may recur so frequently and with such force that they become really obsessive, even in instances not so extreme that there is indication of pathological conditions of the mind in general. We have many times studied the facts concerning young people who have first learned tabooed words under disturbing circumstances, the words then forcibly weaving themselves into mental content and causing emotional stresses and impulsions. That the chain of causation must be brought into the light of full consciousness before effective curative processes can be initiated is now a well accepted fact. The method of aiding the individual to this self-realization is

the analysis of the mental life familiar to those who are acquainted with the work of Freud. In various modified forms, this method is most helpful in studying the mental content.

Our case studies are replete with findings of the bearings of mental content upon social and moral behavior and even upon reactions to educational and vocational adjustments. Only a couple of instances can be given in a few words. A lad of twelve years, generally regarded as a bully and excluded from a boys' club because so much of a "scrapper," said in the course of an interview, "There's something the matter with my mind." On further inquiry, he added, "It's because I always have bad thoughts, bad words," and, after some little persuasion, he wrote on a slip of paper the bad words that he said came into his mind again and again, making him feel irritable and unhappy. "They make me feel like hitting," he said.

Sometimes, in other cases, it is an idea or a thought rather than a word; again, it is a visual image, a picture. Another boy, not yet thirteen years old, was in court after a series of burglaries so remarkable as to become featured in the newspapers. In the course of an inquiry concerning the origin of his impulse to crime, he told of various experiences on the basis of which most vivid imagery had developed. From an older boy he had heard much of stealing: "He made the idea come up in my mind, and sometimes I can hardly get it out. I always think of breaking in. Breaking in comes in my mind every minute sometimes. It's like chains that hold you."

It must be patent that any reëducative process in these cases must be mainly achieved by building up substitutive, good mental content through developing better and more appealing interests. But it is equally true that the essential trouble can never be fairly met until it is really known.

Of course these five phases or aspects of mental equipment upon which we have touched overlap and are interrelated in many ways and influence one another. The dynamic and personality qualities are closely related, and the mental content is determined in part by these as well as by the mental abilities. In the integrated individual, it is difficult to separate them, but for the purpose of analytic and practical study of

the individual, the five aspects of mental equipment should be kept in mind, and the striking characteristics of each noted.

This paper represents of necessity only a cursory and incomplete survey, merely sketching a scheme that has proved useful for purposes both of diagnosis and of recommendation.

The time and effort such study requires have seemed amply justified by the specific social treatment that can be based on the findings and by the successful results in many cases which social treatment so founded has achieved.

PROBLEMS OF SOCIAL CASE WORK WITH CHILDREN *

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THIS paper will assume case work to mean social treatment of a maladjusted individual involving an attempt to understand his personality, behavior, and social relationships, and to assist him in working out a better social and personal adjustment. Treatment may depend largely upon obtaining better environmental conditions, it may center upon bringing about changes in point of view and behavior, or it may involve both in equal degree. In any case, the meaning of certain kinds of behavior and the probable effect upon it of the changing of the social situation must be considered. Needless to say, successful case work will depend not only on the psychological insight brought to it, but on the practical knowledge and handling of every available social resource.

Social case work in this sense is applicable to every individual, child or adult, who is not as well adjusted as his own happiness or the welfare of society demands. It has nothing to do with the problem of relief as such. It does not depend upon our economic system primarily and would be as useful to the socialistic as to the capitalistic state. The rich need it quite as much as the poor, and the good often quite as much as the delinquent. In short, in the last analysis, real case work is nothing but the practical application of mental hygiene to individuals who need it, no matter where they may be found. Some of us are sufficiently adjusted, understand ourselves sufficiently well, to need only the help of friends in untangling our difficulties. Others of us need more professional help from the case worker who combines with her experience in human psychology the practical ability to make the social resources responsive to our needs. Still others of us are so crippled by a long history of bad adjustment and lack of understanding of our own behavior that the insight and skill of

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the psychiatrist are required to set us straight before any external adjustment is possible. The work that is done here all along the line is case work. From the normal to the most abnormal client there is no break, only a gradually increasing difficulty and complexity, requiring a steadily increasing knowledge and skill to deal with it. The social case worker thus far has specialized in the manipulation of environmental factors and social resources. She is now realizing that case work is always fundamentally psychological, or, if you please, psychiatric, even when it is applied to the so-called normal person, and that environment is never external to the psychology of the client.

Social case work as applied to children is as yet rather rare except in a few of the most advanced and highly socialized centers. Treating a child with as much respect and regard for his personality as if he were an adult is a very new thing in children's work—as new as mental hygiene itself. Yet this is what social case work with children implies. Even the charity organizing societies whose pioneer efforts have standardized, if they have not originated, content, technique, and teaching of family case work have only recently, to the best of my knowledge, really taken hold of the problems of the children in their families, except in so far as they were health problems, practical questions of recreation and education, or concerned with the disposition of the delinquent or the mental defective. Their records frequently give very little idea of the personal qualities of the children in the family or of their behavior except when it is so bad as to be disturbing. Then the external facts are reported. This condition is rapidly changing, and children are now beginning to be recorded as personally as adults by some workers.

The public schools, in which every type of problem requiring case work must necessarily arise, are in a few instances meeting the most obvious needs. Mental defect causes such serious maladjustment both to the child and to the school that special or ungraded classes in many city schools are attempting to give the high-grade feebleminded child the individual teaching and social supervision that the normal child must get along without. This, in so far as it is more than a mere herding of all kinds and degrees of defectiveness into cus-

todial groups to save the other classes, is a beginning of social case work in the school, although confined to a limited class. A very few of the most progressive city schools are individualizing their superior children, whose adjustment to the ordinary class is destructive, poor, or, to say the least, unprofitable. A few schools are singling out the undernourished or pre-tuberculous children for particular attention both at home and in school, which is a step in the direction of case work, although concerned primarily with physical health.

The child who demands most attention from the school, however, is the one who gives the most trouble—the persistent truant, the bad boy, the gang member. Unfortunately, this child is so pressing a disciplinary problem that case work as applied is apt to be purely a matter of practical expediency, except in the rare and fortunate school which possesses a visiting teacher whose function is case work with the difficult child. This type of child feeds the delinquent group and is kept from the reformatory only by the truant school or the disciplinary class. Here the idea of punishment or coercion is apt to get the better of case work and any thoughtful attempt at reëducation. The trouble with the public school is that it has so many children and so many practical problems of machinery and organization to meet that it has no time to do case work and does not as yet see case work as its job.

The juvenile court, which has had to grapple with the cases that no other agency would accept, has in many cities taken the lead in a genuine effort to deal with children as persons —not puppets or criminals—whose behavior springs from causes that can be discovered and that may, with understanding and favorable conditions, be modified or entirely corrected. The psychologists and psychiatrists who have devoted themselves to work with the delinquent child have made perhaps the greatest single contribution to the psychology of case work with children. Unfortunately, few reformatory institutions and few probation departments have been equipped with case workers who could continue the psychological understanding or carry out the social treatment indicated by the court psychologist or psychiatrist. Many a valuable experiment has failed to obtain satisfactory practical results because the diagnostic study could never be fairly tested out

in adequate social treatment, since there was no social case work equal to the clinical study. This divorce of clinical diagnosis from case treatment has been the great stumbling-block in the way of practical results in dealing with delinquent children.

There is another group of children, however, which bridges the gap between normal and delinquent and which, from the standpoint of case work, offers the most hopeful and valuable possibilities. This is the dependent group. Its behavior problems are not so socially serious or so immediately pressing as those of the delinquent group, yet it is quite as much in need of the case-work method. It approximates in make-up the average public-school population, with a smaller percentage of superior and a larger percentage of inferior children, yet so far as environment goes it is under comparative control. Here, it seems to me, is the ideal group in which to begin real social case work as applied to children. Every variety of problem is presented, and we set our own social conditions. There could be no more suitable field for studying human behavior and attempting to work out good adjustments between the individual and society at the very beginning. Moreover, it is in this field that the most intelligent and painstaking case work with children is now being done. It is not to be found except in a few of our most progressive child-placing agencies, but it does exist and, where it exists, produces most enlightening and satisfactory results which can be used in all children's work. It is upon the field of child placing, therefore, that I have drawn for the material of this discussion on the problems of case work with children.

These problems can be divided into two groups—problems of traditional attitude and inadequate psychology, and problems of practical resources for social treatment. In a sense they are one and the same, for it is the lack of understanding of children, the rigidity of attitude toward them on the part of the home, the foster home, the agency, the institution, and the school, that makes the resources actually available of so little help. Moreover, a different attitude would of itself tend to create more and better resources, because it would feel the need which is now not recognized even by the more enlightened public. The most difficult problems for the case worker with

children, and the ones that must be solved and re-solved from day to day, are, therefore, first, the problem of acquiring a new attitude backed by an elastic psychology which shapes itself through actual, concrete experiences with children and is ever self-critical and open to new material; and, second, the problem of getting enough of this attitude and this psychology across to teachers, parents, institutions, and foster parents to be able to carry through the social treatment.

Perhaps our greatest handicap as adults in dealing with children is our proclivity for rationalizing both our own and the child's psychology. That, combined with our conventional morality, works the greatest havoc in child life. We like to think of ourselves as primarily rational, intellectual beings, as far as possible removed from impulsive and emotional reactions. We like to think of our conduct as under rational control, and we deceive ourselves very much on that score. We blind ourselves to the primary importance of the dynamic wish, of the will to live, or whatever you choose to call the energic basis of human life. We think of ourselves as acting for the good of society, as choosing this rather than that plan on a purely intellectual basis, as living on the whole the life of reason undisturbed by emotional influences. There are always good explanations for our failures, reasons why we could not have been expected to do thus-and-so on that particular occasion. We are late because an unavoidable delay occurred at home, not because we lingered ten minutes too long in a comfortable bed. We missed church because we really felt a cold coming on, and it was a bad day.

Now, while we maintain this theory of conduct for ourselves, we do not as a rule enforce it rigidly. We allow ourselves lapses, and we pretty much get the things we want all on a perfectly rational basis. But, alas, when we turn this attitude on children, unless we have a sense of humor or a vivid imagination, there is nothing to check our rationalization, as *we* do not feel the prick of the child's desires and thwarted impulses. We become consistent and make practice conform to theory as far as we can. We see the child externally, as an object that ought to be trained to behave rationally. Through him we expiate our own human weaknesses. He is the scapegoat. In him our frailties shall be

corrected. He shall be trained for virtue, to meet the hard things of life. He shall be punctual, neat, clean, industrious, interested in whatever is put before him, fond of the work the adult gives him, ready to play only at the proper time, and prompt to leave that play, however crucial the moment, at the call of bed or meal time. He shall not eat too much or what is not good for him; he shall be taught never to save himself from discomfort by a lie or to gain a coveted object by taking things belonging to other people. He shall be cheerful, obedient, respectful, free from outbursts of temper, jealousy, and selfishness at all times. And above all, regarding that fundamental instinct by which the whole world continues to live, and its particular set of organs in his own body, he shall evince no curiosity.

The child, by virtue of his helplessness and natural inferiority, tends to make arbitrary, autocratic rulers of us all. We can do with him what we will, and as adults we are always right. Too often our discipline of the child or our interference with his activities is based, not on its inherent harmfulness, but on its relation to our personal comfort and the ease with which we dominate the situation. *We* can have our way, but he can't have his. Too often the controversy between teacher and pupil or house mother and child becomes a mere contest of wills, with no inherent virtue on either side, only the deep and rationalistic conviction on the part of the adult that it is fatal to the child's welfare not to have the adult come out victorious. We take too lightly the child's own interests, and the work quality involved in their pursuit. We do not respect his so-called play, which we interrupt so often at our own convenience. We ignore the dynamic force of the child's desires and the inevitability of their finding some form of expression. We do not recognize his need to gain a sense of power, to experience success and superiority, and sometimes to be right when the adult is wrong. The real explanation and understanding of conduct in terms of his wants and feelings will not be apparent until the child becomes in our eyes a *person* worthy of the same respectful consideration that we give to an adult.

The records of children's agencies are full of this lack of understanding. Conventional, adult morality and adult inter-

pretation of conduct in external terms, classified and labeled for all time, is rife in these records. Little Mary, who is five, is put down as sexually immoral, because, forsooth, led on by an older girl, she became interested in her own anatomy and the pleasurable sensations to be derived from it. Johnny, who, strangely enough, has a taste for sweets and no pecuniary means to gratify it, is called a thief because the cooky jar and cake box are not safe from his depredations. Johnny's own mother would expect him to visit the cooky jar. The foster mother or the institution matron has a different point of view. There is no instinctive emotional response here to modify the rationalistic view of child behavior. Alice, just arrived at the mature age of six, is damned forever as lazy and a poor worker because she shows no evidence of enjoying dishwashing or preferring it to playing dolls. When Sammy has done something for which punishment has been promised, Sammy, most surprisingly, will deny it to the bitter end. The truth is not in him. Susie, who is a foundling, is a terrible story-teller. She invents tales of her rich, powerful relatives, when everybody knows she was left on a door step. And so it goes, page after page, bearing testimony to the impeccable standards of the adult and the inherent sinfulness of the child. The real problem for case work here is to learn how to get records of children that will really contribute to an understanding of them.

In reporting on a child's conduct, the average matron, foster mother, or teacher, gives, not a description of specific behavior, but a judgment of the child, a complete classification of his nature, good for all time and predetermining his future conduct. What we have is not an account of Johnny's finding a penny on the mantelpiece the day he especially wanted a certain marble in the corner store, but a labeling of Johnny's inner nature, an identification of Johnny with an abhorrent act. Gradually, but inevitably, Johnny becomes "the kind of boy who takes things." Thus our records tend to be condemnatory moral judgments rather than scientific descriptions of child behavior.

Why do we have such difficulties in observing and reporting a child's behavior? Isn't it because we fail so often to make understanding the child, rather than the success of our

own ideas, our real purpose? Just the genuine acceptance of that purpose and the change of attitude it involves will do more than any other one thing to help us solve our case problems. That which brings out our judgmental attitude, our resentment or disapproval, is conduct on the part of the child that interferes with our purposes. Mrs. Brown has taken Mary into her home, not to help Mary solve her life problems, but to have some one to stay with the baby when she is out. Mrs. Brown means well by Mary; she will give her a good home. But when Mary fails to be reliable with the baby, Mrs. Brown's fundamental purpose is thwarted. Condemnation of Mary is inevitable. Mary is reported to the visitor as an unreliable child who is not to be trusted with babies. Miss Jones' job is to teach so much arithmetic in a given time and maintain order in her room. Jimmy is a stumblingblock to the carrying out of that program. He interferes seriously with Miss Jones' purposes. Resentment, anger, disapproval of Jimmy are natural consequences. Even the best intentioned case worker sometimes forgets to set her purpose in terms of an understanding of the child and a working out of the best possible adjustment from his point of view. She has found such a fine home for Mary. There is a big yard, and a well-furnished house, considerable culture in the family, many educational advantages—but Mary refuses to be happy there. It is human nature to be out of patience with Mary, who thus upsets all her carefully laid plans.

There is only one cure for the personal resentment, the emotional reaction, that so often vitiates our observation and treatment of children, and that is really to set up as our purpose something that cannot be interfered with by the child. There is only one purpose that answers to this description—the very purpose not to put over something of our own, but to observe and to understand behavior, whether good or bad, and patiently to determine what adjustment, if any, the child is capable of making. To such a purpose Johnny in a tantrum is just as fulfilling as Johnny in an angelic mood. All is grist that comes to our mill. Johnny can no longer hurt us. It is hard to maintain this attitude. Other desires creep in and are thwarted; we react in anger or disappointment. The only salvation for us as professional case workers, whether with

children or adults, is to re-present to ourselves constantly the fundamental object of our work whenever we fall from grace. Only in this way can we free our judgments from the taint of our own emotions and ourselves from the bitterness of disillusionment.

The case worker with dependent children faces a peculiarly difficult situation in that the dependent child, by virtue of his very dependency, is always potentially a behavior problem. The family background on which the mental health of every child must largely depend is in his case inevitably distorted. Thus at the very root of dependency is the soil of potential maladjustment. The normal child develops in strength and confidence on the basis of the security and assurance that the mother and father supply. He has the possibility of achieving a wholesome and necessary sense of power because he has this stable foundation on which to fall back when his sense of safety is threatened. He can be sure of his home. It will not vanish overnight. Father and mother are all-powerful and can save from every ill. The family may oversupply the love and backing which the child demands and make a weakling of him, but on the other hand the absence of such an assurance of safety is equally fatal to the growth of a normal self-confidence and free, outgoing energy.

The child who lacks this fundamental protection becomes at once a prey to fear, uncertainty, and inferiority. He must always be seeking a possible shelter, always hunting a substitute for his natural love objects, always defending himself from the exposure of his inherent weakness and comforting himself with dreams and pretenses and substitute activities. Not that the child does these things consciously and deliberately. He can seldom explain what is back of his troublesome behavior. It is for us to re-create continually in imagination the picture of the dependent child's essential insecurity and inferiority, to understand the compensatory factor in his behavior and work out as best we may a reasonable substitute for the family support he craves. That is why mere excellence of physical conditions is not enough; emotional needs must be met in our placements. The personal equation is more powerful than material good. The reason why Mary in the good home persists in her secretive, sullen ways, the reason why

Johnny masturbates, takes things, or runs away, may easily lie just here, and these behavior problems will be solved only when their cause is understood by the worker.

Besides the sense of inadequacy which the dependent child must carry for lack of family safety and normal love life, he must also suffer the social inferiority that his status entails among other children. The hunger for importance that a relative lends is pathetically obvious in a dependent group. The child who cannot add to his own glory by stories of the achievements of his relatives is terribly handicapped among his mates. Small wonder that such a child calls an inventive imagination to his aid and supplies his need as best he may with the wild romancing that goes down against him in the agency's record.

Surely nothing more is needed to add to the potential behavior problems of the dependent, and yet as a matter of fact two other handicaps are likely to be found in this group—a poor physical equipment, due to inheritance or environment, and a leaning toward the dull normal rather than toward the superior in intelligence. This does not mean that there are no superior children among dependents, but that, taking the dependent group as a whole, we find a larger percentage of below average and a smaller percentage of above average children than are found in the ordinary public school. That is, the type of family that is broken up and whose children become public charges tends to be of inferior mental and physical caliber as compared with the general population. All inferiority—family, social, physical, or mental—produces defense reactions. With a group so characterized by all these lacks, we may expect to have the most difficult and prevailing behavior problems, which can be dealt with only by workers who understand the psychology involved and endeavor to provide an environment that will supply the needs in a great measure or reduce the sense of inferiority by lowering the environmental level to meet the ability of the child.

Coming now to the question of practical resources for carrying out the case-work plan with the dependent child, if we omit the medical problem, we can group most of our difficulties about two critical situations—case treatment for the problem child with good general ability and case treatment for the

child who is inferior, but not defective mentally and is almost inevitably a behavior problem also. The most essential factor in the placement of the first type of child is, it seems to me, the understanding foster home; whereas the second child is more dependent upon the enlightened public school. Such a division is, of course, a matter of only relative importance. Both home and school are necessary in both cases for satisfactory treatment.

Treatment for the bright, but difficult child means the finding of a foster mother who wants to help solve a problem, who is genuinely and objectively interested in children and would like to make her contribution to social welfare in this fashion. The woman who wants the child just to fill up her life and meet her own love needs is not the person we are after. She will resent lack of emotional response in the child, and will be hurt continually by his ingratitude and misconduct. Neither can we use the woman who wants chiefly help in the kitchen or with the children. For the difficult child will only increase her work and thwart her fundamental desire to be assisted in her labor. This, too, will result in anger and disapproval for the child, who needs patience and reassurance. The woman who expects to be paid for her work, but who will look upon the child as her job, may be just the person we need if she has the intelligence and the proper personal qualifications. There is also the woman with the natural gift for managing children, who will not understand the problem in intellectual terms, but will get the results. She is the born mother, with the patience of Job, an intuitive understanding of the weaknesses of human nature, and a practical common sense in her methods of correcting them. No foster home will do that has not in it a woman who will accept the child as a problem and have the patience to work at this problem instinctively or intelligently over as long a period of time as seems necessary.

Can we hope to find such women? They have been found by child-placing agencies doing the best type of work. They are not necessarily found ready made. Some educational work in a community on the part of the agency may be necessary to uncover such homes, and the case worker may have to develop the ideal foster mother out of raw, but promising material; but that is part of her job. The case work of the child-placing

agency must inevitably be done with foster parents as well as with children. The case worker has to interpret to the home the behavior of the child, has to explain the problem, has to help over the hard places and show the family the improvement that has already taken place, encouraging them to persist or to try other methods. With the backing of such a family atmosphere, the bright, but difficult child may often be adjusted quite satisfactorily in the ordinary public school, as his troubles are not due primarily to lack of ability to do the school work.

With the distinctly inferior child, no amount of home treatment can undo the effect of his inevitable and constant failure to come up to public-school standards. It is here that we get our most serious problems of delinquency, beginning and confirmed. If the case problems presented to me by child-caring agencies in Philadelphia during the past year and a half are any criterion, the crucial situation in all children's work is lack of suitable school opportunities for the dull-normal child. In Philadelphia, at least, and I am sure in the vast majority of city public schools still running along conventional academic lines, there is no possibility of obtaining for the dull-normal child, who has become a behavior problem because of his sense of inferiority and failure, the treatment that will touch his case—a school program suited to his abilities. He is not allowed by law to leave the public school when it gets beyond him, yet to face failure, ridicule, reprimands, day after day, is something that human nature cannot do without efforts to escape from so unbearable a situation. The child will either run away in body or in spirit. He is bound to gain a sense of importance somehow—if not by good conduct, by bad. He will take refuge in sullenness, indifference, or in more active, aggressive attempts to counteract the boredom and inferiority of his position. If he cannot shine in school, he can perhaps become the terror of the neighborhood. There is only one possible treatment for this type of child, and that is to offer him legitimate avenues of successful expression. If school or work offers him a chance to act successfully, he will seek social approval, just as he apparently sought social disapproval before. All you need to do to prove this statement is to put such a child into a school that gives him

work in which he can succeed. He becomes the simplest of case problems. His energy goes over into useful activity and drains off from the unsocial channels. Often he is a new child in so short a time that the change seems almost magical. Let the dull-normal child use his hands first and his intellect second, put him with his peers and not his superiors, and in the majority of cases he will cease to be a problem.

This grouping of children is of course far too simple. There are many children both bright and stupid who find social adjustments so difficult that special attention both at home and at school is necessary. There are children who persist in bad or peculiar behavior even when every requirement seems to have been met in the way of home and school treatment. Case work here is probably wasted until the psychiatrist has gone to the root of the difficulty with the child and relieved the conflicts and repressions that underlie his behavior. The time required for this type of preliminary treatment is so great as to make it impossible at present for any large number of children. The hopeful thing for those of us who work with children is the comparative ease with which many behavior difficulties may be straightened out, when the worker, understanding the defense nature of the child's reactions, is able to provide an environment in which defense is unnecessary.

Case problems with children, as with adults, arise through some blocking of the main trends of life—love and creative work. We have to remember that, in the last analysis, the success of our treatment depends upon obtaining for the child at least a minimum of fulfillment in both.

THE MODERN SPECIALIST IN UNREST: A PLACE FOR THE PSYCHIATRIST IN INDUSTRY*

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INDUSTRIAL medicine exists; industrial psychiatry ought to exist. That industrial medicine exists is attested by the founding of national and local societies, journals, personnel groups, and by the pursuit of researches; industrial psychiatry, while it has logical claims to existence, has hardly taken shape. In a paper on *The Movement for a Mental Hygiene of Industry* appearing in MENTAL HYGIENE for January, 1920, I have collected those few references which indicate the probable future course of industrial psychiatry, of industrial psychology, and of the new field of psychiatric social work as applied to industry. In that communication on the general aspects of the new movement I tried to state the issues for non-medical readers, especially for those advanced engineers, employment managers, and other industrialists who see more in industry than either its "efficiency" aspect narrowly taken, or its "welfare" aspect narrowly taken. I would be pleased if I could, in the present communication, awaken the interest of psychiatrists themselves to what must be conceived as another immediate addition to the community functions of the psychiatrists. In some sense, then, the present communication is a foil to my earlier paper written for laymen on the movement in general.

I seize the opportunity afforded by the fortieth anniversary of the founding of the Boston Society of Psychiatry and Neurology for the present purpose, because that society is well representative of the two sides of psychiatry that have developed, rather independently, from the necessities of the state-care program for the insane on the one hand, and from the necessities of private psychiatric and neurological (in-

* Presidential address at the fortieth anniversary of the Boston Society of Psychiatry and Neurology, January 15, 1920. Reprinted from *The Journal of Industrial Hygiene*, Vol. II, pp. 11-19.

cluding medico-legal) practice on the other. This society, made up as it is of both kinds of psychiatric practitioner, public and private, ought to be especially sound upon new matters like the development of industrial psychiatry, which touches public, social, and individual interests alike. As my hearers are thoroughly aware, between the work of the public psychiatrist—whether busied with hospital administration and treatment or concerned with medico-legal decisions—and the work of private practitioners in neurology or psychiatry—men busied with the individual problems of diseases for the most part falling short of the asylum degree—there has come recently to fairly complete logical development the new field of social psychiatry, a field wherein the problems of the probate court and the problems of the consulting office are amplified, developed, and pursued in a hundred ramifications in the social web. Many of our public practitioners of psychiatry——that is, the institution men of the commonwealth of Massachusetts—are already convinced of the value of psychiatric social work in this new intermediary field which lies between the fields of public practice and private practice in mental diseases as these fields have been construed up to recent times. The files of the Psychopathic Hospital will soon contain many thousand socially investigated cases, derived from Boston and the surrounding metropolitan district. But private practitioners in neurology and psychiatry are also becoming aware of the values of the psychiatric social worker for any private practitioner who takes his job seriously and seeks to solve his psychiatric problems with all modern aids.

The three fields of public, social, and individual practice in psychiatry are thus well logically in mind in Massachusetts, as indeed they are becoming clear to most other Atlantic seaboard states and to all urbanized communities that have faithfully undertaken the work of mental hygiene on approved lines. Yet some of us, I fear, may still regard this intermediary field of social psychiatry more as a theory than as a condition. Luckily the men who think practice more important than theory are fast dying out or undergoing belated conversion through reflection on the successes of theory in the Great War. If, however, you actually do meet one of these incorrigible practical men who will see nothing in theory, it is as a

rule enough to show him the results of social psychiatric practice among the relatives of the victims of neurosyphilis—general paresis and the like—to convince him that mental hygiene has unlocked a brilliant and efficacious novelty for public health in its work upon the so-called "syphilis of the innocent." I make this point about social psychiatric practice somewhat at length not so much for my present hearers as for others who may read the printed remarks and wonder whether after all there exists a personnel to attack such widely ramifying problems as those of industrial psychiatry. There does exist the appropriate personnel for work in industrial psychiatry. There is, to be sure, not enough such personnel; but there do exist competent workers who can be multiplied as soon as industrialists begin to crave this personnel and as soon as psychiatrists see the peculiar values of the new work.

Why do I speak of the mental hygiene of industry? Why should the medical man enter fields like those of psychology and social work, fields in which he is not competent by special training or by daily experience? We all know that there is a border line between the work of psychiatrists and the work of psychologists, and that claims and counterclaims have been made by representatives of psychiatry and psychology. Why is it not better for psychiatrists to pursue their own expert ways, leaving psychologists to theirs? We are all aware that heated discussions have taken place in the national associations anent, for example, the so-called "diagnosis of feeblemindedness," which seems a medical problem to the psychiatrists and an educational problem to the psychologists. It seems to me, however, that although heated discussions upon abstract lines may occur at society meetings, there is absolutely no practical or concrete difficulty in marking out the peculiar uses of the psychiatrists and the psychologists in particular, concrete cases of mental disease or defect. For example, at the Psychopathic Hospital the work of Professor R. M. Yerkes, psychologist to the hospital, ran with perfect smoothness alongside of the work of the psychiatrist in the hospital wards and the out-patient service. On these practical grounds, as well as on sound theoretical grounds, I conceive that it is both tactical and strategic to place psychiatric art and psychological science under the one

head of "mental hygiene," a term which has medical suggestions, but which has also equally pronounced suggestions of normality and health. Where so many of our problems in the social division of psychiatric practice lie along this border line between normal and abnormal, I conceive that the term mental hygiene is perhaps the best that can be found to describe the sudden enlargement of the psychiatric range in recent years. But, together with the psychiatrist and the psychologist, I would also range a psychiatric social worker as a third kind of mental hygienist. The mental hygiene of industry will of course require the services of all three types of mental hygienists, as I endeavor to make plain in my communication for laymen entitled *The Movement for a Mental Hygiene of Industry.* As psychiatrists and physicians, we shall not forget the importance to mental hygiene in general of mental hospital nurses, of occupation workers, and of specialized types of teachers for mental diseases and defects. But these latter varieties of mental hygienists are not so much in point in the primary field of industrial psychiatry. In that field a working party, composed of psychiatrist, psychologist, and psychiatric social worker should, if possible, have added thereto a person skilled in tabulation and statistics.

I have just employed the phrase *working party* in the mental hygiene of industry. Such a working party should be of value in almost all other fields of mental hygiene—for example, in the survey of a state or district, an occupation group, a racial group, or any other special group of persons whose mental hygiene demanded attention. Parenthetically, I am sure you will all agree that there is hardly any group of persons in the world that would not benefit from mental-hygienic analyses made upon the triple lines herein indicated. Thus, such a working party, composed of psychiatrist, psychologist, and social worker, can already be found in advanced juvenile courts, and even certain courts for adult cases, and would undoubtedly be of the utmost service in all domestic-relations courts. Again, in schools, in various institutions for the care of children, this combined insight would penetrate many a dark corner.

But industry seems to me to be the problem to-day nearest

to the hands of mental hygiene. One is impressed with the readiness of industry for such working parties in mental hygiene. The war has brought industrial problems into sharp relief; reconstruction has altered the focus in places, but has not abolished the problem. Above all, there is at the present day the so-called industrial unrest, a problem met apparently with not too great intelligence, if we can judge by the nullities and silent dispersal of certain national industrial conferences in our country. To be sure, the Royal Commission on Industrial Unrest in England during the war time (1917) did important service in laying down certain concrete findings and recommendations, but those results were war-time results confined to Great Britain. The psychiatrist who reads the Royal Commission reports can scarcely avoid being convinced that greater and more significant results could have been obtained if the principle of the mental-hygiene working party could have been adopted in the British investigation.

A word or two is in place about the respective functions of the members of a mental-hygiene working party. For the benefit of those who come to this problem for the first time, let me insist that such a working party is not proposed for the purpose of supplanting the employment or personnel manager or any other major or minor executive in the industrial plant. I hope to convey by the term working party the idea of an investigation, occasional rather than permanent, carried out by special officers having the weight of certain connections outside of the industrial plant themselves. Of course the psychological examiner will no doubt prove a relatively permanent portion of the organization of an industrial plant as soon as plant managers get clearly in mind the successes of psychology in the army in the classification of personnel and in the elimination of the unfit through group and individual mental tests. Probably this aspect of the propaganda for mental hygiene may be regarded as properly under way, though, in my opinion, certain plants have been adopting it more as an efficiency device than as a welfare or social adaptive measure. But the tendency to exploit the values of mental measurement for the mere elimination of the individual from a particular plant will be short-lived if we can somehow kindle the spirit of mental hygiene in the whole industrial problem.

After all, the psychological examiner will find himself of greatest value in the employment or hiring side of the plant's work. As the years pass, the psychologist may also learn to contribute to the problem of promotion upon lines of vocational psychology. But for the present the psychological examiner, in the narrow sense of this term, will be of decidedly lesser value in the interpretation of the discharge rate or turnover in industrial plants. The industrial plants should have the lists of discharged employees gone over from time to time by a consultant psychiatrist or a neurologist interested in the psychiatric side of this work. Such consultant psychiatrist should be in complete touch with the psychological examiner and should have at his disposal such records of mental testings or other recorded impressions as the psychologist may have. He should likewise be able to secure and interpret the records of social work, especially those made in connection with discharged employees.

The psychiatric social worker, like the psychological examiner, will probably become a permanent element in the plant, although most of her work may well be done outside its walls in the community and especially in the families, even of those who become industrially disabled and of those who are discharged, when the reasons for their discharge are consistent with the spending of the plant's time and money on their families. Luckily, in advanced urban communities the standard of social welfare has been advanced at least to the point reached by the standard of efficiency inside the plants. The result is that by a minimum of exertion on the part of the social worker, proper transfers of these families of discharged workmen to other agencies can be arranged for. Where there are a number of industrial plants in a single community, the social workers connected with these plants would naturally be closely associated with one another in their social conferences and society meetings. Industrialists tell us that coöperation is more the order of the industrial day than competition. However this may be in industry as a whole, there can be no doubt that the social treatment of families of employees discharged from plant A will benefit the turnover sheet of plants B and C, etc. If plants B and C employ social workers of

like skill, plant A will in turn benefit in its turnover sheet. In brief, the welfare of the discharged to a certain extent means the efficiency of the plant. The general problem of turnover is aided by the well-known principle of mutual "back scratching." Meantime, the welfare values obtained for the community as a whole run beyond the superficial relief of the industrial skin.

How soon it will be possible to make physicians in general and medical social workers, not especially trained or expert in mental problems, see eye to eye with the psychiatrist and the psychiatric social worker in this matter of the mental hygiene of industry is hard to say. However, from the operations of national and local societies of industrial medicine, it appears that physicians in general are becoming much alive to the virtue of this new combination of medicine and engineering. Psychiatry has made such strides in relation to the more superficial problems of social work that psychiatrists are often overwhelmed with the kind and degree of expectation uttered by social workers. The extreme range of such expectation is shown in the files of the out-patient department in the social service of the Psychopathic Hospital in Boston. Much is expected of the psychiatrist in the new social division of his practice.

It is particularly in the grievances that come to the attention of the employment manager that the psychiatrist will find his work laid out. In the communication on *The Movement for a Mental Hygiene of Industry* above mentioned, I have quoted from Read a list of causes for removal from a certain large payroll. The following entries will readily suggest to the psychiatrist what sort of investigation ought to be carried out, especially with the aid of the psychiatric social worker:

Certain Causes of Removal from Payroll

Did not like supervision.	Dishonesty.
Refused to be transferred.	Drinking.
Resented criticisms.	Fighting.
Did not like working conditions.	Indifference.
Work too hard.	Insubordination.
Agitator.	Too slow.
Carelessness.	

There is also a paragraph called "superintendent's private file" among the "unsatisfactory" group of removals that might well be looked into by the consulting psychiatrist. Where do all these grudge-bearers, agitators, drinkers, fighters and lazy persons go? Some of them figure within a comparatively short time in the discharge files and turnover analyses of nearby plants. We may talk of the solution of such problems as the duty of the community, but it should not be long before industrial plants themselves recognize the efficiency and welfare virtues of attending as strictly to their human outgo as to their human intake. I mentioned the work of the British Royal Commission on Industrial Unrest in 1917. I present a summary of their findings made by the Right Honorable G. N. Barnes, M. P., not because all of the fourteen items are particularly related to our own or to any special problem in industrial hygiene, but to show the general nature of the Royal Commission's work.

Summary of the Industrial Unrest Findings in England, 1917, by G. N. Barnes, M.P.

1. High food prices in relation to wages, and unequal distribution of food.

2. Restriction of personal freedom and, in particular, the effects of the munitions-of-war acts. Workmen have been tied up to particular factories and have been unable to obtain wages in relation to their skill. In many cases the skilled man's wage is less than the wage of the unskilled. Too much centralization in London is reported.

3. Lack of confidence in the government. This is due to the surrender of trade-union customs and the feeling that promises, as regards their restoration, will not be kept. It has been emphasized by the omission to record changes of working conditions under schedule LL, article 7, of the munitions-of-war act.

4. Delay in the settlement of disputes. In some instances ten weeks have elapsed without a settlement, and after a strike has taken place the matter has been put right within a few days.

5. Operation of the military-service acts.

6. Lack of housing in certain areas.

7. Restrictions on liquor; this is marked in some areas.

8. Industrial fatigue.

9. Lack of proper organization among the unions.

10. Lack of commercial sense; this is noticeable in South Wales, where there has been a break-away from faith in Parliamentary representation.

11. Inconsiderate treatment of women, whose wages are sometimes as low as £13.

12. Delay in granting promises to soldiers, especially those in class "W" reserve.

13. Raising of the limit of income-tax exemption.

14. The workmen's compensation act; the maximum of £1 weekly is now inadequate.

Among the recommendations of the British commissioners are to be found recommendations concerning:

1. Food prices (of which the commission stated there should be an immediate reduction with an increase price partly borne by the government and with a better system of distribution).

2. Industrial counsels on the principles of the Whitley report.

3. Authoritative statements by the government as to further increase of output (war-time conditions).

4. Participation by labor in the affairs of the community as partners rather than as servants.

5. Publicity in certain matters relative to leaving employment.

6. Publicity by the government concerning its pledges already given.

7. Raising of the £1 maximum under the workmen's compensation act.

8. Announcement of the policy as regards housing.

9. Skilled supervisors to receive bonus.

10. Closer contact to exist between employer and employee.

11. Pensions committee to be granted more discretion. Treatment of men discharged from the army.

12. Certain agriculturists' wages to be raised.

13. Colored labor not to be employed in ports.

14. A higher taxation of wealth (by one commissioner).

According to the commission's report, there were the following four universal causes for unrest in England: (1) food prices and distribution of supplies; (2) restriction of personal freedom;(3) card system for military and industrial service; (4) incoördination of government papers. Certain acute, though not universal, causes of unrest were housing, drinking, and fatigue. The commission also speaks of "psychological" conditions and remarks that "the great majority of the causes of industrial unrest specified in the (8 district) reports have their root in certain psychological conditions." Among these may be mentioned lack of confidence in the government, feeling of inequality of sacrifice in army and industry, the idea that solemn pledges were broken and turned into "scraps of paper," feeling of unreliability of certain trade union officials, and feeling of the uncertainty of the whole industrial future.

The commission was no doubt justified in laying enormous emphasis on what it calls "psychological" conditions. The psychiatrist and the medical men in general must feel that the blanket term psychological condition covers a good many psychiatric difficulties. Thus, whoever follows the strong trend to individualization in medicine, psychiatry, in education —both intellectual and moral—and even into the law courts, must be convinced that individualization should proceed to greater lengths in industry. There is nothing more widespread in modern sociology than certain ideas about group action as the "be all" and "end all" of progress and failure in social developments. As one author puts it, group experience leads to group thought, group thought to group action. If we take, for example, the universal causes of unrest summarized by Barnes of England, we shall of course be convinced that food prices might well be a group experience; a poor distribution of supplies might be to a large extent a group experience. There would also be a group experience of the evils of card systems which might lead to group thought, and unrest of mind might create tendencies to strikes; distribution of supplies would tend to follow group experience and thought as in the case of prices and service cards. When it comes, however, to a question of the restriction of personal freedom and to a question of government incoördination, it must be observed that these are hardly group experiences as much as individual experiences. The workman who objects to being passed automatically from one sphere of labor to another may make himself heard effectively in group thought; the victim of some incoördination on the part of government departments may do the same. But it certainly must be true that the effects of such restriction of freedom and of temperamental incoördination are, as a rule, individual. The voices of the victims, however, are raised along with the voices of general unrest concerning food prices and the service-card system.

We cannot help thinking that the principles of social work and especially of psychiatric social work, applied to the problems of the restriction of personal freedom or of temperamental incoördination, will solve most of the problems. The matter of automatic transfers from certain spheres of labor is of course a war rather than a peace matter, but the item will

serve as well as another to indicate that universal causes of unrest need not be the product of group experience, need not have led to group thought, and need not lead to group action unless in the presence of other more general causes of unrest. Many of these problems, possibly the majority of them, are extraordinary rather than main problems. The same holds for the "acute" as contrasted with the "universal" causes of unrest, most of which acute causes are described by the commissioners as arising locally from different problems, such as family housing, drinking, fatigue, or even such a problem as that of lack of confidence in the government, specified among the findings as lack of commercial sense (No. 10). We find from the commission's report that this lack of commercial sense was especially noticeable in South Wales where there had been a break-away in faith in parliamentary representation. I do not know any single important fact relative to South Wales and its break-away from the democratic faith, but certainly there must have been a local condition which no doubt had local causes, some of which are almost certain to have been due to the operations of a particular man or group of men.

This introduces us to the most general aspect of the unrest problem, the aspect which leads me to give to my paper the somewhat cryptic title of *The Modern Specialist in Unrest.* It may be—or, as I suspect, it may not be—that group experience leads to group thought and group thought to group action as the ordinary course of events in social developments. But whether these developments are group matters or not, it remains true that most of the information which we possess concerning group psychology and group psychopathy is derived from the psychology or the psychopathy of the individual. If this statement be accounted true, then I do not need to insist that the psychiatrist is rather more likely than any other expert to know how the main lines of unrest will run. Unrest on the part of the individual is the big problem of the psychiatrist; year in and year out he comes in contact with the finest, as it were, and the most brilliant examples of unrest in the shape of particular patients in his wards. If this general account of things be correct, the psychiatrist ought to have a message for industry. Psychiatric knowledge about

the unrest of the individual ought to be turned to account in our analyses of group unrest.

The main thesis of the present communication is that a psychiatrist has a place in industry. I think that he will have a place in the routine of industrial management, not as a permanent staff member (save in the instances of very large firms and business systems) but as a consultant, at stated periods, relative to the matter of grievances, complaints, and dissatisfactions, actual and potential. The function of this occasional consultant would be preventive rather than curative of the general conditions of unrest. How far we can think of the industrial psychiatrist not merely as a preventive agency, but as a curative agency for conditions of unrest, the future must decide.

What is unrest? The theory that group experience leads to group thought, which in turn leads to group action, may be sound theory for a portion of industrial phenomena, but individual experience, individual thought, and even individual action are also factors in industrial situations. How far is unrest a matter of group or crowd or mass psychology? How far does mass psychology depend upon the psychology of the individual member? It will not be wise to generalize to the effect either that industrial unrest is entirely a group phenomenon or that it takes its rise entirely in the minds or in the hearts of individuals. We have seen that some of the causes of unrest in England might well be matters of group psychology, but that other causes of unrest seem almost in their nature to have been of individual origin.

That portion of the unrest problem which depends not upon group experience, but upon individual experience, not upon group thought, but upon individual thought, and finally not upon group action, but upon individual action, is the proper topic for the psychiatrist. The psychiatrist, particularly in company with the psychiatric social worker, has always been a specialist in unrest—unrest, to be sure, confined within asylum walls. The modern psychiatrist has under more or less definite supervision large numbers of the so-called psychopathic personalities—persons who are not insane in a kind or degree to warrant their commitment to institutions, but who are psychopathic enough or in such wise as to benefit from

community supervision. It is this modern contact with the psychopathic personalities, with instances of so-called psychopathic inferiority, with psychopathic states, that makes the modern psychiatrist a specialist in a kind of unrest that interests the community very deeply. These psychopathic personalities have been recognized even in the immigration laws and in the official tabulations of the army and navy under the terms "constitutional psychopathic inferiority," "constitutional psychopathic state," and similiar designations.

It is important for the modern psychiatrist not to "hide his light under a bushel"; he must step forth to new community duties. It is on this account that I conceive that a recent step of the Engineering Foundation, representing the United Engineering Society, is of so much importance. Among the earliest problems undertaken by the Engineering Foundation is the problem of the mental hygiene of industry. To the writer, as Director of the Massachusetts State Psychiatric Institute, was entrusted a research of definite dimensions, relative to the mental hygiene of industry and the problem of mental abnormalities in relation to industrial personnel. The enlightened officers of the Engineering Foundation immediately found the ramifications in the research of mental hygiene of industry so numerous and so broad that a plan is being mooted for the investigation of the entire problem of industrial personnel. On the suggestion of the Engineering Foundation, the National Research Council appointed a committee, composed of representatives of its divisions of anthropology and psychology, educational relations, engineering, industrial relations, and medicine, to consider the scope of investigation into industrial personnel.

It seems to me that as psychiatrists we should help this movement wherever it becomes practically possible. The practical possibilities of helping lie in connection with the fact that the majority of our male patients have either come out of industry or are going back into industry in some capacity. Special investigations of the individual patients with respect to their industrial status and future should be made. The information which the psychiatrist possesses concerning personality, temperament, and special abilities, as modified by mild mental disease and defects, should be at the call of the

employment manager. There should be a drawing together of the psychiatric and industrial interests of all communities. The psychiatric social workers of the state institutions should meet similiar workers from the industrial plants to discuss the individual fates of particular discharged workmen. Psychopathic persons can be fitted into industry far more successfully than most psychiatrists and industrialists are feign to believe. The employment work at the Psychopathic Hospital during the last four years has definitely shown these adaptations of the psychopathic employees to be numerous and effective.

I do not need to rehearse to this audience the early conclusions of Dr. Adler concerning unemployable personalities, based upon Psychopathic Hospital studies, more than to recall the immediate subdivisions which he made into the problems of fitting into industry (a) the feebleminded, (b) the cyclothymics, and (c) the paranoiacs. Every employment manager is aware of the existence of the feebleminded and of their availability for certain kinds of work. Industrialists are also quick to recognize the cyclothymic with their ups and downs of emotional mood as actual inhabitants of mills and mines, and much can quickly be taught the employment manager concerning the special virtues and faults of these victims of the cyclothymic constitution, and even of the more severe forms of manic-depressive psychosis. The paranoiac patient is ready to be recognized by the employment manager as a man with a grudge or chip on his shoulder. In fact, the task of letting in a little psychiatric light upon these problems is not so difficult as might be conceived; the success of Psychopathic Hospital clinics for employment managers in the summer of 1919 attests the value of spreading these practical doctrines of mental hygiene among industrialists.

MENTAL DEFICIENCY

Its Frequency and Characteristics in the United States as Determined by the Examination of Recruits

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OF the 72,323 cases of nervous and mental disorders identified by the neuropsychiatric examiners of the Medical Corps of the army detailed in the United States, 22,741, or 31.4 per cent, were mental defectives. The mental defect was so pronounced that the bulk of these recruits were considered unfit for any kind of military service. They constituted nearly one-third of all the rejections for nervous or mental causes, and were far more numerous than any other single clinical group. If the mental defectives rejected at the local boards are added to those rejected at camps, the total number of individuals seriously handicapped by mental defect brought to light by the mobilization reaches 26,545.

The question naturally arises as to how thorough the examinations were—as to how nearly the number of rejections for mental defect corresponded with the actual number of defectives enrolled. Two facts indicate that the weeding out was not only thorough, but prompt. One of these is that comparatively few defectives were reported from the American Expeditionary Forces, as they would have been had they been permitted to go to France. Up to June 1, 1919, only 1,475 of these cases had been admitted to Base Hospital 214, A. E. F., the receiving point for returning cases. As this number is about 10 per cent of the neuropsychiatric cases admitted to that hospital, and about 5 per cent of the U. S. cases of mental defect that were prevented from going to France, it would seem an inevitable conclusion that the bulk of mental defectives enrolled did not leave the United States. Another fact

to be considered in this respect is that the number of military offenses reported both in this country and in France falls far below the original estimates. As defectives are prone to delinquencies of all kinds, their absence from the army must be accepted as an important factor in the low delinquency rate.

But while the figure of 26,545 undoubtedly represents the bulk of mental defectives originally called to the colors, it does not represent all of them. It does not include the cases (aforementioned) found in France and returned to this country from the A. E. F., or those found at the demobilization examinations. Also, some were discharged under a different diagnosis than mental defect; some were disposed of directly by the court; some were discharged as unfit under Paragraph 148½ A. R.[1] Also, numerous border-line cases were accepted by the examiners. Some of these higher-grade defectives became part of the army, settled to low strata of usefulness, and served through the war.

The clinical and statistical data that form the substance of the present communication were obtained from detailed reports submitted by the neuropsychiatric officers to the Surgeon General's Office. There these reports were checked up, verified, classified, and studied in detail. This study is based upon reports received from 21,858 mental defectives—a number surprisingly large in view of the magnitude of the undertaking. The records proclaim mental deficiency to be far and away the most frequent of all conditions with which psychiatrists have to deal. It might well be considered as the psychiatrist's most urgent present problem. This statement is justified by reason of the frequency and wide distribution of mental defect, its close social and economic relations, and especially because, in spite of those facts, it has hardly begun to be recognized as a problem at all, and no efforts adequate to meet it have been undertaken.

[1] "When an enlisted man is inapt, or does not possess the required degree of adaptability for the military service, or gives evidence of habits or traits of character which serve to render his retention in the service undesirable, or is disqualified for service, physically or in character, through his own misconduct, his company or detachment commander will report the facts to the commanding officer, who will convene a board of officers, three if practicable, to determine whether or not the soldier should be discharged prior to the expiration of his term of enlistment . . ." *Regulations for the Army of the United States,* Art. XXI, Par. 148½, p. 37. Washington: Government Printing Office, 1913.

Mental defect is approximately three times more frequent than drug inebriety, concerning the terrors of which the press keeps us constantly informed; it is twenty times more frequent than disabling alcoholism, to prevent which our federal Constitution has been amended; it is three times more frequent than insanity, in provision for which there is a general quickening of interest throughout the country, and for the cure of which at least half a dozen of our states have developed systems of the highest order of merit.

Mental defect, with its enormous number of handicapped individuals who condition our penal system and systems of education and economic development, is almost totally neglected by the federal government, and in no state is it considered with foresight and intelligence by the legislators.

Number of Male Mental Defectives in the United States

The most important question arising from this inquiry is: how many mental defectives are there in the United States? The answer to it vouchsafed by the army figures, while perhaps not absolutely accurate, may be not far from correct. If the number of men examined be approximated at 3,500,000, there would be a ratio of 6.5 defectives for every 1,000 men examined. The number of cases discovered at the local boards is so small that the preceding ratio may be used in estimating the number of mental defectives between the ages of twenty-one and thirty-one years, exclusive of those confined in state and private institutions. There were 10,101,506 registrants between the ages of twenty-one and thirty-one years and the ratio of 6.5 per 1,000 would give, for this number, 65,650 male mental defectives of the given age period.

If mental deficiency ran uniform among persons of all ages, there would be 353,210 male defectives in the United States; if uniform for the ages between eighteen and forty-five, there would be 164,710 male defectives in this group.

As a matter of fact, we know that mental defect, by reason of the high mortality incident to it, especially in youth, has a greater incidence in groups under eighteen years than in those over it. So it seems evident that the estimates drawn from adults would understate the number as related to the entire population.

The information obtained from the survey made by the army neuropsychiatrists falls into two categories, one of which has to do with facts especially important to the army and the other with facts important to the civil community. In the first it is shown that certain differences exist between volunteers and draftees; how defectives were identified in the army; when—that is, at what point of their military life—they were found; and finally what disposition was made of them. The second category deals with clinical and sociological data in regard to mental defect in general.

Mental Deficiency Among Volunteers and Draftees

The men examined from whom the candidate-officers group and voluntary-recruit group of Table No. 1 were prepared voluntarily offered their services at a time when every one was free to enlist or to apply for admission to the officers' training camps. The draft-recruits figures were drawn from a number of camps. The lower percentage of mental deficiency in the volunteer, as compared with the conscripted, troops is to be remarked. This difference is explainable by the fact that mental defectives are apt to stay at home and have less opportunity for contact with recruiting officers. At the same time, enough of them do offer their services to create a problem in raising an army of volunteers. For example, recent reports from recruit depots indicate that they constitute 28 per cent of the neuropsychiatric cases found among present applicants for the new army, or 10 in every 1,000 men.

Among neuropsychiatric patients, alcoholics alone offer themselves more freely to the army than do mental defectives.

How Mental Defectives Were Detected

Mental defect as a social condition reveals itself particularly in disorders of conduct. These cannot be kept secret or hidden. They come to light sooner or latter, and then leave little doubt that the defective individual is not apt as a soldier. But their thus coming to light of themselves, in a military organization, is a process at once slow, expensive, and dangerous. It is slow, as during training considerable time is required to determine whether behavior indicating mental

dullness or stupidity is a thing that can be corrected by training or not; it is expensive, as the soldier receives pay, maintenance, and equipment, wastes the time of the officers who try to teach him, and holds back his brighter comrades; it is dangerous, as there is always the risk that some stupid boy will be assigned to a position of responsibility.

The neuropsychiatric officers undertook to shorten this process, to insure the immediate and definite separation from the service of all recruits and enlisted men who were markedly deficient in intelligence.

As shown in table No. 2, they operated in several ways. The first and most serviceable method of elimination was furnished by the neuropsychiatric examinations, which ultimately were coördinated with the regular camp examinations, and which took place immediately upon the arrival at camp, or other point of recruitment, of each new quota of recruits. Psychiatric methods of examination were employed, supplemented in doubtful cases by individual psychological tests. It is shown in the table that in this way delay was reduced to the minimum in 42 per cent of the cases.

Twenty-eight per cent of the mental defectives discovered were referred by medical officers, and 25 per cent by line officers, notably captains of companies. These two percentages disclose the satisfactory coöperation that existed between the specialists and the officers of the army as a whole. As far as medical officers were concerned, any doubt—and where will be found a more fertile cause of delay than may have existed in their minds?—as to the nature of the diagnosis was relieved by the consultation, so that they could proceed confidently to the necessary steps to discharge. Hospital beds were thereby relieved.

But, from a military point of view, even more important was the coöperation that was promptly established between neuropsychiatrists and line officers. For the first time in the history of the army, commanding officers found generally available specially trained men to assist them in their understanding and management of soldiers in whom strange and unusual conduct might be explained by mental defect. This coöperation became still more effective when the position of division psychiatrists was created, which assured, for the first

time, the availability for troops in actual combat of an officer specially experienced in mental defects and diseases. Previously, all specialists had been detailed almost exclusively to hospital services. The new position assured the assignment of neuropsychiatrists to tactical divisions, which implied a close association with troops both in training and in the fighting areas. The benefits of this innovation became immediately evident in our cantonments and later in France.

Only a small number of mental defectives were referred to the neuropsychiatric division by psychologists. This fact is not to be construed as a reflection upon the effectiveness of psychological methods, or upon the coöperation between psychologists and neuropsychiatrists, as originally contemplated. But as the psychologists were not medical officers, their recommendations with respect to discharge had to pass through the hands of medical officers before being referred to commanding officers for action, and the arrangements were that such recommendations should be submitted to the neuropsychiatrists. The small number of recommendations thus referred was due to a failure in administrative arrangements. It would have been of advantage if the group tests could have been applied throughout the army to precede the regular neuropsychiatric examinations. Wherever they were used systematically and coördinated with the camp examinations, they were helpful and expedited matters. But their utilization, as far as the detection of mental deficiency was concerned, met serious administrative difficulties, with the result that the part played by the psychologists in the elimination of mental defectives was small. It will be noted in the table that the psychological examinations brought to light a higher percentage of mental defect among the colored troops than among the white. Psychiatric officers found difficulty in getting in touch with the negro psychology and, with the exception of those who lived in the South and knew the negro thoroughly, often hesitated in deciding whether an individual case was defective or not. In such cases it may well be that a formal, impersonal method of approach, such as the psychologists use, is preferable.

There were only 562 white and 71 colored cases, diagnosed mental deficiency, referred to the neuropsychiatric officers for

opinion as to the causes of misconduct. But, with these small numbers, mental deficiency heads the list of neuropsychiatric conditions found among the army offenders, as 40.5 per cent of the white and 64 per cent of the colored delinquents who were *neuropaths* were of the mentally defective type.

Mental deficiency was not so frequent among the neuropathic delinquents at Leavenworth as it was among such individuals in the camps. This fact may indicate that the mental defectives are the petty offenders and the individuals who commit only misdemeanors. There was brought to our attention an interesting case history in which the statement of the keeper of the guardhouse was related. The statement was as follows: "This man has been in the guardhouse ever since he came into the service. He says he likes the work, and thinks that the guardhouse is the best part of the army."

Length of Service of Mental Defectives

As stated by the general staff, the average length of the training period of soldiers who went overseas was six months. Consequently, while it was important to eliminate undesirables at the earliest moment possible, it was imperative to eliminate them before their assignment to the expeditionary forces. Table No. 3 shows that, prior to the expiration of the average training period, 18,858, or about 90 per cent of the total number, had been identified. As already stated, there were 1,475 mental defectives recorded in the one central receiving point for such cases in the A. E. F. These cases were probably made up of those who were ordered overseas contrary to the recommendation of the neuropsychiatrists, those who were recommended for limited service and who received overseas orders nevertheless, and those who were not identified under six months or not identified at all.

It seems probable that many of them were border-line cases. Of the 1,475 reported as admitted to Base Hospital 214 as mental defectives, only 762 reached the ports of the United States under that diagnosis. Many of these may have been put back on a duty status, after treatment in hospital and subsidence of the reactionary episode—so common among the feebleminded under strain and excitement—that caused their admission.

A slightly higher percentage of colored cases than of white ones was discovered in the first three months and a slightly lower one after the first six months.

Recommendations and Military Disposition

Tables Nos. 4 and 5 should be taken together, and in considering them it should be remembered that in all matters pertaining to the disposition of soldiers, the function of the medical officer is purely advisory. He forwards his recommendations to higher authority, and the higher authority acts upon them as it sees fit. The recommendations of the neuropsychiatric officers went first to the superior medical officer for remark before being forwarded. It was, therefore, inevitable that there should occur certain discrepancies between the recommendations of specialists and the action taken upon them by the discharging and assigning authority of the army.

It was to have been expected that the introduction of a new method such as the neuropsychiatric method should be regarded with misgiving and distrust by many of the older officers. This misgiving and distrust are, perhaps, in part represented by the difference between the number of mental defectives recommended for discharge and those actually discharged —namely, 2,510, a number considerably in excess of the number of mental defectives ultimately reported in the A. E. F. It is probable that some of those thus retained were discharged finally, nevertheless, upon a second recommendation or after the arrival at the camp of another commanding officer.

Also, the neuropsychiatric officer was not often in a position to know what action had been taken on his recommendations. He rarely had time or opportunity to inquire himself, and no one informed him. One of the things he was longest in learning was that his recommendations for discharge were not necessarily followed by a separation from the service. It thus also follows that the total records, when made up in the Surgeon General's Office, were in some respects incomplete, as is shown by there being 1,877 recommendations action upon which is unknown.

The tables show the small number of defectives who were returned to full duty, and the proverbial freedom from physical illness of the mental defective is substantiated by the fact

that out of 21,000 cases only 76 were retained in the hospital for treatment. The association of mental defect with other neuropsychiatric conditions will be referred to in a later paragraph.

Classification of Mental Defect

In the classification of the mental defectives discovered in the army, the conventional definitions were employed: an imbecile was considered as one capable of guarding himself against common physical danger, but incapable of earning a living; a moron as one capable of earning a living under favorable circumstances, but incapable of competing on equal terms with his normal fellows.

No idiots came under the observation of the neuropsychiatric officers, and among the whites the morons constituted approximately two-thirds of the total, the imbeciles one-third. The negroes showed a higher percentage of grave defects, as among them the imbeciles totaled 48.4 per cent and the morons, or higher grades, sank to 50.7 per cent. Of the 3,804 cases rejected at local boards, as reported in the report of the Provost Marshal General, no classification as to mental grade was made. The present statistics refer to a definite group, and so it is not possible to compare the classification derived from them with classifications obtained in civil life.

The following comparisons are, however, interesting.

Of mental defectives for whom admission to a general state institution is sought there are approximately

	Number	Per cent
Idiots	163	8
Imbeciles	1,142	56
Morons	736	36

Among mentally defective juvenile delinquents as referred to a children's court there are

	Number	Per cent
Imbeciles	910	91
Morons	90	9

The definitions applied to the various grades of mental defect make it plain why these individuals should be elimi-

nated from an army—at least from a first-line army. Some critics, basing their opinions upon the good work that some mental defectives can perform under favorable circumstances, especially on farms, have maintained that too many defectives were eliminated from the army—that, if retained, they could have filled satisfactorily many offices, that they could stop bullets as well as the others, etc.

These arguments would have more weight if the mental defectives among the recruits had been subjected, prior to the draft, to the special training without which few mental defectives can work in coöperation with others. It is now generally known that the effectiveness of a mental defective depends less, within certain limits, upon the grade of mental defect than upon the habits of *doing* that he has acquired. An individual with the mental age of eight years, who has definitely acquired habits of industry, obedience, and regularity, is a far more useful member of society than a high-grade moron who has never acquired such habits. It is the quality of training that has been given, rather than the intellectual level, that concerns the employer of this variety of labor, whether such employer be a recruiting officer or some other.

Granted, then, that mentally defective recruits would not have been serviceable in the army unless subjected to training, the question arises as to whether the military training would have fitted them to be soldiers. As implied in the definition of mental defectiveness, special-training battalions would have had to be organized, for, put in with the general troops, the defectives would have hindered military development just as a backward child hinders the progress of the general class.

Our army in the recent emergency was totally unprepared to meet any such exacting training program, and even if it had been prepared to meet and fulfill it, to have undertaken to do so would have been unwise in the extreme. The successful training of a defective requires specially trained medical men and attendants, and should be carried out in appropriately equipped and situated institutions and extend over a period of at least one year. Even then the work to be expected from the defective is not of a high order, is essentially manual, and attains its highest degree of usefulness in agriculture,

It would seem, then, that in war the methods of training

defectives should be the same as in peace, with the same ends in view so far as service to the country is concerned. Defectives should be looked to to aid in the sustenance of an army rather than in the actual carrying out of campaigns. They should not be discharged at draft boards or camps until efforts have failed to convert them into some use to the country. These efforts should be in the direction of militarizing existing institutions which are located in good farming districts and in sending to them those defectives who would under present arrangements be rejected for military service.

Association of Mental Deficiency with Other Neuropsychiatric Disorders

Table No. 6a contains interesting figures covering mental deficiency as a base for the development of neuropsychiatric disorders in general, of which psychoneurosis was the most frequent single variety. One and three-tenths per cent of defective whites and 1.7 per cent of colored defectives were psychoneurotics—an incidence four or five times as great as among average soldiers. The most prevalent forms were hysteria and psychasthenia, neurasthenia being frequent. The frequency of hysteria in mental defectives as observed in the cantonments is in entire agreement with the results obtained in the hospital for returned psychoneurotics at Plattsburg, where mental defect was noted as being especially frequent in hysterical cases.

Next to psychoneurosis, the neuropsychiatric condition most frequently associated with mental defect is epilepsy, which confirms the observations of civil life. In fact there is a certain equivalence between epilepsy and mental defect, due possibly to the failure of examiners to distinguish sharply between the two conditions. Of institutional epileptics, 90 per cent are defective, and doubtless at the camps cases of epilepsy with conspicuous mental retardation were diagnosed as cases of mental deficiency. At a number of camps it was noted that if the mental deficiency rate fell below the average, the epilepsy rate was above it, and vice versa.

The other figures in the table speak for themselves. The types of constitutional psychopathic states were paranoid

personality, pathological liar, and sexual psychopath. The chief neurological disorders were syphilis of the central nervous system, tremors, tics, and chorea.

Family History

The information covering family history—Tables Nos. 7, 7a, and 7b—is open to the criticism that it was furnished by a class of patients less qualified to be accurate about such matters than any representative of the neuropsychiatric group. Mental defectives, when questioned about their forbears, may well be suspected of not having the knowledge that would enable them to give correct answers. They might, and probably would, know if members of the immediate family have been in an institution, but they might be unaware of the existence of the psychiatric conditions. This would be particularly the case for mental deficiency itself which, in certain sections of the country, exists as a family characteristic and so would not be remarked by members of the family. This probably accounts for the low percentage of mental defect shown in Table No. 7a. It is also probably responsible for the fact that psychopathic inheritance in mental deficiency —Table No. 7—appears so low. It is lower than in any other neuropsychiatric group, except drug addiction, alcoholism, and organic nervous diseases.

In about four-fifths of the mental defectives discovered in the army, the histories recorded data on these points. Such inheritance existed in a little more than one-half of the whites and a little less than one-half of the colored.

In Table No. 7b attention is invited to the large number of mothers among both the white and colored who had nervous diseases and to the large number of inebriates, chiefly alcoholics, among the fathers. Mental diseases and defects are about equally balanced between fathers and mothers among both the white and colored.

The same table shows the large number of brothers and sisters—listed in the table as siblings—who were victims of nervous diseases and mentally defective. This fact is true for both the white and the colored. Mental diseases also ran high among the brothers and sisters of the colored mental defectives.

The heading "collateral," which appears in table No. 7b, includes uncles, aunts, and cousins. The table shows the small number of mental defectives among this group of relatives and also the large number of cases of mental disease.

Age

Table No. 8 gives the ages of the mental defectives. Fewer cases of the colored were found to be under twenty years of age, the greater percentage of the colored being between the ages of twenty and twenty-five years. In the other age groups the percentages do not vary greatly.

It is difficult to make any exact comparison between the ages of the mental defectives and of other soldiers because the ages of all men in the service have not yet been published. Partial comparisons can be made with the report of the Provost Marshal General, which contains data on 77 per cent of the men in the service. Of the men placed in Class No. 1 between the ages of twenty-one and twenty-nine, 62 per cent were between the ages of twenty-one and twenty-four, and 38 per cent between the ages of twenty-five and twenty-nine. The corresponding percentages for the cases of mental deficiency are 58 and 42. The difference of only 4 per cent would probably justify the conclusion that between the ages of twenty-one and twenty-nine there is no appreciable difference between the ages of a group of mental defectives and normal individuals.

When the ages of mental defectives are compared with the other groups of neuropsychiatric cases, different facts appear. About 10 per cent of the white cases were under twenty years of age, which percentage is the largest for any group, constitutional psychopaths and epileptics standing next in order of frequency. The percentage of mental defectives over thirty years of age was smaller than for any other group except the endocrinopaths. The percentage for the epileptics was only slightly larger than that of the mental defectives. Among the other groups, the percentage of individuals over thirty years of age ran from 5 to 20 per cent higher than the percentage for the mental defectives.

The variations of the percentages for the different diagnoses for the colored do not differ greatly from those for the

whites, except that there is practically no variance among the percentages for the cases under twenty years of age.

If the information relating to ages can be safely interpreted in terms relative to mortality, they indicate that in a group of neuropsychiatric cases over thirty years of age the percentages will be the smallest for mental defectives, epileptics, and endocrinopaths.

Residence

In discussing the question of place of residence, the Provost Marshal General states that in the examination of the records of 200,000 registrants from urban and rural districts,[1] 21.7 per cent of those from urban districts were rejected, while the rejections from the rural districts were 16.9 per cent. In other words, the Provost Marshal General says: "Considerable physical advantage accrues to the boy reared in the country."

Table No. 9, which gives the residence of the cases of mental deficiency, shows that two-thirds of the cases come from the rural districts. The generally accepted explanation of this is that the great flocking to the cities which is so characteristic of our times is a movement carried out by those of the community who are progressive and have initiative, while the mental defectives stay where they are.

According to the census of 1910, 51 per cent of the whites and 73 per cent of the colored resided in the rural districts. On comparing these percentages with those of table No. 9, it is found that mental deficiency is far more frequent among the whites in the country than in the cities. For the colored the percentages are the same, which is an indication that the negro of the city does not differ from the negro of the rural districts in so far as mental deficiency is concerned.

Of all the neuropsychiatric disorders among both the white and colored, mental deficiency is the only one for which the percentage coming from rural districts exceeded the percentage of the population residing in rural districts. There is no doubt about the information being accurately recorded, as a thorough investigation of the 1,500 cases from New York

[1] A community of less than 2,500 inhabitants is considered as rural.

showed that the larger percentage of the cases resided in the counties which did not have large cities or towns and are classed as rural.

Education of Mental Defectives

The degree of education of mental defectives is best considered in connection with Table No. 10a, prepared by the psychological officers of the Sanitary Corps, which shows the results of their inquiries into the education of drafted men as a whole. This table provides a form for comparison, and one is struck first of all, on comparing it with the table showing the education of male defectives, by the great difference between the education given the normal and that given the defective. In considering it, it should be borne in mind that the class here under discussion is composed of the higher grades of defectives, those who are, in many respects, educated. Yet one-third of the whites and two-thirds of the colored have had no education at all. No effort, apparently, was made to teach them. Fifty-nine per cent of the defectives had had some schooling, but only a small number reached high school and the only college representatives were found in the officers' training camps.

The differences in the efforts at education of the blacks as compared to the whites is conspicuous. The fact that such a large number of the blacks received no education may account in part for the large number reported by the psychologists as being defective.

Economic Condition of Mental Defectives

The classification adopted in Table No. 11 as to economic condition does not include those usually referred to as indigent, as a recruit accepted at the local board was no longer indigent. By "marginal" is understood a condition in which an individual could not subsist for four months without working and without becoming a public charge.

The percentages of the white and the colored mental defectives in marginal circumstances were larger than the percentages for any other group. On account of the relation

which the economic condition bears to education and standard of living, the figures presented here are very significant of the necessity of action by some governmental or charitable agency if the condition of the mental defectives is to be improved. Since people in marginal circumstances are not usually well fed, the question of how much mental retardation is due to malnutrition is then presented.

Venereal Diseases

The usual motive for denying the existence of venereal disease did not exist in the army, and officers were struck with the frankness with which soldiers spoke of their past life in this respect. The figures here represented must stand by themselves, as the army statistics relative to venereal diseases refer only to the actual existence of them, not to past histories. It is impossible, therefore, to state how mental defectives compared with those mentally normal in giving a venereal history. Table No. 12 shows a remarkably low percentage of pre-existing venereal diseases among whites and a low percentage among the colored. This corresponds with civil experience as concerns mentally defective males, as the sexual instincts are frequently very dormant among this class of individuals.

Attention is invited to the fact that the admissions of the existence of infections of any kind were about four times higher among the colored than among the whites. Syphilitic infections were about eight times higher among the colored and gonorrheal infections were about four times as great.

Among the mentally defective whites the percentage for all venereal diseases was lower than for any other group of neuropsychiatric disorders; among the colored the percentage was lower than for any other group except cases of alcoholism.

Syphilitic infections among the mentally defective whites were very low; the percentage was equaled, however, by the endocrine group and was not much larger than the percentages for the epileptics and the psychoneurotics. Among the mentally defective colored, the percentage was smaller than for any other group except cases of psychoneurosis. Gonorrheal infections were very low among the whites; among the

colored the percentage was larger than those for the cases of alcoholism and psychosis.

Alcoholic Habits

There is practically no difference between the white and colored cases of mental deficiency in so far as alcoholic habits are concerned. This fact is shown by Table No. 13. It is not possible to compare these figures with any other data, as no information is obtainable, but comparisons of the mental defectives with the entire group of neuropsychiatric cases and with particular neuropsychiatric disorders is possible.

The percentage of moderate drinkers for both white and colored is slightly larger than the percentages for all neuropsychiatric cases. Among the whites, the percentage of intemperate cases was smaller than the percentages for epileptics, psychoneurotics, and endocrinopaths. The latter facts are true for the colored, except for the endocrinopaths, where the percentage of intemperate cases was larger than that for mental defectives.

Marital Condition

Table No. 14, which gives data relative to the marital condition, shows that over 15 per cent of the mental defectives were at one time married. The percentage of marriages is about three times greater among the colored than among the whites. The percentage of divorces is also higher among the colored.

The percentage of marriages ran lower among the mentally defective whites than for any other group of neuropsychiatric disorders. Divorces were also lower, except for the endocrine group. Among the colored the percentage of marriages was smaller than for any group except alcoholism. The percentage of divorces among the colored mental defectives was slightly higher than those for the epileptics, endocrinopaths, drug addicts, insane, and constitutional psychopaths.

In considering the data relative to marital condition, it should be remembered that most of the men in the military service were not married. On account of this fact, it has not been possible to compare the data with any other except those

relating to the army. The report of the Provost Marshal General, which contains data on 77 per cent of the men in the army, states that 13.2 per cent of the men placed in Class No. 1 were married ("married" included widowed and divorced). Including widowed and divorced in the married group of mental defectives, we find that 15.7 per cent were married. This percentage, while not much larger than the figures for Class No. 1 men, may be significant of the fact that married mental defectives were placed in Class No. 1 by reason of failure to support their dependents, or that they enlisted to avoid family responsibilities.

Classification of Mental Defectives by Race

On account of the mixture of races so common among the population of the United States, it is difficult to draw any definite conclusions concerning race and mental deficiency. From the figures given in Table No. 15 some facts are discovered that may be of significance. The percentages of mental deficiency are much higher for the Mexicans, American Indians, and the negroes. Next in order come the Armenians, Slavs, and Italians, followed by the English and French.

The percentages of the races discussed above are larger than the figure for the median, which is 28.5 per cent. Of the races that appear in the group below the median, the Scotch stand the lowest, with 12.4 per cent. The Welsh and Hebrews come next; their respective figures are 15.3 per cent and 17.2 per cent. The Greeks and Scandinavians form the next group, with percentages of 23.6 and 23.8. The Dutch, German, and Spanish appear next to the median.

Nativity

As no information on the nativity of the men in the army has been published, it is not possible to determine exactly if mental deficiency was more or less frequent among the native than among the foreign born. Table No. 16 shows that 9.5 per cent of the cases of mental deficiency were of foreign birth. Using all the neuropsychiatric cases for the purpose of comparison, it is found that 10.5 per cent were foreign born. As this percentage does not differ greatly from the percentage for mental defectives alone, the conclusion seems correct that

mental deficiency did not exist to a greater extent among the foreign born.

The conclusion would be altered somewhat by facts arising in considering the following: the number of immigrants denied admission on account of mental deficiency, the number of children among those admitted, and the ability of the psychiatric examiners and the psychologists to discover through their tests and examinations all possible cases of mental deficiency among persons of foreign birth.

By referring to Table No. 16a, the number of cases of mental deficiency coming from each foreign country may be ascertained. If the exact number of men in the army from each of the countries was available, some comparisons could be made as to the percentage of mental deficiency among each group. The information can be compared, but not so satisfactorily, in the following manner: use the total number of neuropsychiatric cases from each country as a base and determine what percentage of them were mental defectives. The percentages for this calculation are given in Table No. 16a. The percentages are high for Austria-Hungary, Italy, Poland, and Russia. This fact may be explained by reason of the large number of children among the immigrants from these countries; also by the failure of the tests of the Bureau of Immigration to detect cases of mental deficiency among the immigrants of this class. Note the small percentages for England, Scotland, Wales, Switzerland, Scandinavia, and France.

Table No. 16b gives the number of white and colored mental defectives born in each state. If the figures in this table are compared with Table No. 17, it may be determined how many more or less cases are residing in a state than were born there. For instance, the residents of Alabama gave birth to 435 of the white and 711 of the colored mental defectives; the same state had only 397 of the whites and 656 of the colored living there. In other words, the other states had among their mental defectives 38 whites and 55 colored, which were received from Alabama, for which the latter state received none in return.

The residents of the state of New York gave birth to 814 of the white and 12 of the colored mental defectives, and 412 of the whites came to the state from foreign countries.

Deducting the last figure from the total whites, it is found that the state of New York received 45 white and 35 colored mental defectives from the other states.

Calculations similar to the ones made in the preceding paragraphs may be made for each state in the Union. The results may be of no particular value because of the inability to prevent a mental defective from going where he is taken by his parents. The information may, however, be interesting to people who wish to determine the localities that furnish more than their quota of the large number of mental defectives.

State of Residence

In order that the different states may determine the local importance of mental deficiency, there appears in Table No. 17 the number of white and colored mental defectives residing in each state and percentages that show the relation of mental deficiency to other neuropsychiatric disorders.

White: Among the whites for the entire United States, mental deficiency constituted 29.2 per cent of all the neuropsychiatric disorders. In nineteen states the percentages were larger than that for the United States. The relative positions of these states and their percentages are as follows:

1. Maine	51.5	11. North Dakota	38.5
2. North Carolina	46.7	12. Alabama	36.0
3. Virginia	45.5	13. Mississippi	35.4
4. Maryland	44.9	14. Missouri	33.8
5. Arkansas	43.7	15. Vermont	33.6
6. South Carolina	43.4	16. Georgia	33.3
7. Tennessee	43.0	17. Oklahoma	33.3
8. New Mexico	41.4	18. South Dakota	33.1
9. Kentucky	41.1	19. Florida	31.1
10. West Virginia	38.6		

Attention is invited to the fact that all of the states in this group except four are Southern states.

The percentages for two of the states, Michigan and Rhode Island, were equal to, and the percentages for twenty-eight states were below, that for the United States. The relative positions of these states and the percentages are as follows:

1. Arizona	15.0	16. Colorado	24.8
2. District of Columbia	16.1	17. Nebraska	25.1
3. Montana	16.7	18. Iowa	25.3
4. Oregon	18.1	19. Texas	25.5
5. Nevada	18.3	20. Massachusetts	25.7
6. Illinois	19.9	21. Washington	26.1
7. New York	19.9	22. Idaho	26.7
8. Utah	20.5	23. Connecticut	26.7
9. Kansas	21.6	24. Pennsylvania	27.0
10. Wyoming	21.8	25. Wisconsin	27.0
11. California	22.0	26. New Jersey	27.5
12. Minnesota	22.2	27. New Hampshire	27.7
13. Delaware	22.8	28. Louisiana	28.8
14. Indiana	23.3	29. Michigan	29.2
15. Ohio	23.9	30. Rhode Island	29.2

Colored: The percentage of mental deficiency among the colored neuropsychiatric cases was 48.3. Seven of the states exceeded the figure for the United States. The percentages for these states were as follows:

1. Maryland	74.4	5. Oklahoma	57.9
2. Tennessee	71.8	6. District of Columbia	52.7
3. Alabama	66.4	7. Virginia	48.6
4. Arkansas	62.4		

Note that Maryland, Tennessee, and Askansas are also near the top of the list that gives the same information concerning the whites.

The states for which the percentages equaled or were less than the percentage for the United States were as follows:

1. Florida	11.5	13. Ohio	33.5
2. Iowa	12.6	14. Delaware	37.5
3. California	14.3	15. West Virginia	37.5
4. New Jersey	21.0	16. Kentucky	38.5
5. Kansas	21.6	17. Rhode Island	40.0
6. Missouri	24.4	18. South Carolina	40.0
7. New York	29.2	19. North Carolina	40.8
8. Georgia	31.7	20. Illinois	41.0
9. Indiana	32.6	21. Pennsylvania	42.0
10. Michigan	32.6	22. Mississippi	44.6
11. Massachusetts	33.3	23. Louisiana	48.3
12. Texas	33.4		

This list is peculiar in that Florida and Georgia stand near the top. The states in the last two columns are about evenly divided between the North and the South.

Residence of Foreign-born White Mental Defectives

In Table No. 18 there appears the number of foreign-born white mental defectives residing in each state. From this table and Table No. 17 those interested may ascertain how immigration is related to the state's problem of mental deficiency. For instance, in Connecticut and Rhode Island, the foreign-born mental defectives constituted about one-half of all the cases of mental deficiency. In New York and Massachusetts, about one-third of the cases were of foreign birth. In New Jersey, Pennsylvania, Michigan, California, and Washington, the foreign-born equaled from one-fourth to one-fifth of the total. In many of the other states the ratios were from one-sixth to one-ninth of the totals.

TABLE NO. 1

Mental Deficiency among Volunteers and Draftees

	Number examined	Cases of mental deficiency	
		Number	Per cent
Candidate officers	12,291	7	0.06
Voluntary recruits	75,881	413	0.54
Draft recruits	626,825	3,952	0.63

TABLE NO. 2

How Mental Defectives Were Detected

	Total		White		Colored	
Referred by	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Psychiatrists in routine examination	8,975	42.3	7,271	42.2	1,704	42.8
Other medical officers	5,907	27.9	5,046	29.3	861	21.6
Commanding officers	5,468	25.8	4,525	26.3	943	23.7
Psychologists	761	3.6	294	1.7	467	11.8
Court	82	0.4	78	0.5	4	0.1
Unascertained	665	....	589	....	76	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 3

Length of Service of Mental Defectives Prior to Time of Discovery

Service	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Under 1 month	11,708	56.2	9,212	54.4	2,496	64.3
1–3 months	4,534	21.8	3,753	22.1	781	20.1
4–6 months	2,616	12.6	2,178	12.9	438	11.3
7–12 months	1,440	6.9	1,320	7.8	120	3.1
1–2 years	406	1.9	377	2.2	29	0.7
Over 2 years	118	0.6	99	0.6	19	0.5
Unascertained	1,036	....	864	....	172	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 4

Recommendation of Psychiatrists for Disposition of Mental Defectives

Recommendation	Total		White		Colored	
	Number	Per cent	Number	Per cent	Number	Per cent
Discharge	18,785	85.9	15,419	86.6	3,366	83.0
Treatment	76	0.3	66	0.4	10	0.2
Duty	206	1.0	194	1.1	12	0.3
Limited service	2,791	12.8	2,124	11.9	667	16.5
Total	21,858	100.0	17,803	100.0	4,055	100.0

TABLE NO. 5

Military Disposition of Mental Defectives

Disposition	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Discharged	16,275	81.5	13,232	82.1	3,043	78.8
Retained	3,689	18.5	2,873	17.8	816	21.1
Absent without leave	10	0.0	8	0.1	2	0.1
Died	7	0.0	6	0.0	1	0.0
Unascertained	1,877	....	1,684	....	193	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 6

Classification of Mental Defectives

Degree	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Imbecile	6,817	32.6	4,881	28.8	1,936	48.4
Moron	13,242	63.2	11,215	66.2	2,027	50.7
Border line	880	4.2	846	5.0	34	0.9
Unascertained	919	....	861	....	58	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 6a

Association of Mental Deficiency with Other Neuropsychiatric Disorders

Disorder	Total	White	Colored
Psychoses	113	100	13
Psychoneuroses	296	230	66
Constitutional psychopathic states	98	89	9
Nervous diseases and injuries	99	86	13
Epilepsy	179	126	53
Endocrine disorders	54	47	7
Drug addiction	16	14	2
Alcoholism	63	63	...
Total	918	755	163

TABLE NO. 7

Family History of Neuropsychiatric Conditions among Mental Defectives

	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Positive	9,533	53.7	8,103	55.0	1,430	47.2
Negative	8,222	46.3	6,624	45.0	1,598	52.8
Unascertained	4,103	....	3,076	....	1,027	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 7a

Family History of Neuropsychiatric Conditions among Mental Defectives

Family history of	Total Number	Total Per cent[1]	White Number	White Per cent[1]	Colored Number	Colored Per cent[1]
Nervous disease	3,456	36.3	2,967	36.6	489	34.2
Mental disease	2,855	29.9	2,146	26.5	709	49.6
Inebriety	3,028	31.8	2,630	32.5	398	27.8
Mental deficiency	1,752	18.4	1,478	18.2	274	19.2

1. Based upon total number of mental defectives (9,533) giving a family history of neuropsychiatric conditions.

TABLE NO. 7b

Classification of Family Neuropsychiatric Conditions among Mental Defectives, According to Disorder and Relative

Family history of	Father	Mother	Grandparents	Siblings[1]	Collateral[2]
White					
Nervous disease	686	1,542	79	1,419	376
Mental disease	353	403	194	650	972
Inebriety	1,963	55	55	781	446
Mental deficiency	244	243	9	1,339	151
Colored					
Nervous disease	110	196	32	399	139
Mental disease	83	113	52	264	432
Inebriety	248	18	8	196	87
Mental deficiency	32	36	3	292	52

1. Includes brothers and sisters.
2. Includes uncles, aunts, and cousins.

TABLE NO. 8

Ages of Mental Defectives

Years	Total Number	Total Per cent[1]	White Number	White Per cent[1]	Colored Number	Colored Per cent[1]
Under 20	1,763	8.4	1,685	9.8	78	2.0
20 to 24	10,151	48.1	7,878	45.9	2,273	58.1
25 to 29	6,950	32.9	5,782	33.7	1,168	29.8
30 to 34	2,045	9.7	1,692	9.8	353	9.0
35 and over	185	0.9	143	0.8	42	1.1
Unascertained	764	....	623	....	141	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 9

Residence of Mental Defectives

	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Urban[2]	7,169	33.9	6,081	35.6	1,088	27.0
Rural	13,966	66.1	11,022	64.4	2,944	73.0
Unascertained	723	....	700	....	23	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.
2. A community having less than 2,500 inhabitants is considered rural.

TABLE NO. 10

Education of Mental Defectives

	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
None	8,517	41.1	5,729	34.3	2,788	69.7
Grades	12,011	58.0	10,805	64.7	1,206	30.2
High school	98	0.5	93	0.6	5	0.1
College	25	0.1	25	0.1	0	0.0
Foreign schools	52	0.3	52	0.3	0	0.0
Unascertained	1,155	....	1,099	....	56	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 10a

Education of 80,000 Soldiers

	White Per cent	Colored Per cent
None	3.2	13.5
Grades	75.2	76.0
High school	16.6	8.9
College	5.0	1.6
Total	100.0	100.0

TABLE NO. 11

Economic Condition of Mental Defectives

	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Marginal	19,816	95.4	15,865	94.5	3,951	99.2
Comfortable	959	4.6	927	5.5	32	0.8
Unascertained	1,083	....	1,011	....	72	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 12

Venereal Diseases among Mental Defectives

	Total		White		Colored	
Any venereal diseases	Number	Per cent	Number	Per cent	Number	Per cent
Admitted	4,490	20.5	2,282	12.8	2,208	54.5
Denied	17,368	79.5	15,521	87.2	1,847	45.5
Total	21,858	100.0	17,803	100.0	4,055	100.0
Syphilis						
Admitted	1,466	6.7	517	2.9	949	23.4
Denied	20,392	93.3	17,286	97.1	3,106	76.6
Total	21,858	100.0	17,803	100.0	4,055	100.0
Gonorrhea						
Admitted	4,077	18.7	2,231	12.5	1,846	45.5
Denied	17,781	81.3	15,572	87.5	2,209	54.5
Total	21,858	100.0	17,803	100.0	4,055	100.0
Others						
Admitted	337	1.5	171	1.0	166	4.1
Denied	21,521	98.5	17,632	99.0	3,889	95.9
Total	21,858	100.0	17,803	100.0	4,055	100.0

TABLE NO. 13

Alcoholic Habits of Mental Defectives

	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Abstinent	8,499	41.5	6,873	41.6	1,626	40.9
Moderate	10,089	49.2	8,100	49.0	1,989	50.1
Intemperate	1,914	9.3	1,556	9.4	358	9.0
Unascertained	1,356	....	1,274	....	82	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 14

Marital Condition of Mental Defectives

	Total		White		Colored	
	Number	Per cent[1]	Number	Per cent[1]	Number	Per cent[1]
Single	17,885	84.3	15,161	88.2	2,724	67.4
Married	2,971	14.0	1,813	10.6	1,158	28.7
Widowed	172	0.8	87	0.5	85	2.1
Divorced	201	0.9	128	0.7	73	1.8
Unascertained	629	....	614	....	15	....
Total	21,858	....	17,803	....	4,055	....

1. Of ascertained cases.

TABLE NO. 15

Classification of Mental Defectives by Race

Race	Number	Per cent[1]
African	4,055	48.3
American Indian	78	62.9
Armenian	26	37.7
Dutch	86	26.2
English	2,651	29.2
French	274	29.1
German	1,217	28.0
Greek	67	23.8
Hebrew	226	17.2
Irish	936	21.0
Italian	803	32.7
Japanese	0	0.0
Mexican	257	66.9
Philippino	3	0.0
Porto Rican	1	0.0

TABLE NO. 15—concluded

Classification of Mental Defectives by Race

Race	Number	Per cent[1]
Scandinavian	296	23.6
Scotch	72	12.4
Slavonic	915	37.0
Spanish	31	28.5
Welsh	13	15.3
Others	237	34.1
Mixed	6,490	27.5
Unascertained	3,124	....
Total	21,858	....

1. Based on neuropsychiatric totals for each race.

TABLE NO. 16

Mental Defectives Classified According to Nativity

	Number	Per cent[1]
Native white	15,558	71.8
Native colored	4,047	18.7
Foreign-born white	2,061	9.5
Unascertained	192	....
Total	21,858	....

1. Of ascertained cases.

TABLE NO. 16a

Classification of Foreign-born White Mental Defectives by Country of Birth

	Number	Per cent[1]
Austria-Hungary	154	31.1
Canada	72	21.4
England, Scotland, and Wales	30	9.3
France	10	20.4
Germany	48	25.7
Greece	58	24.0
Ireland	59	28.4
Italy	663	32.5
Netherlands	22	25.6
Poland	144	43.5
Russia	538	32.1
Scandinavia	85	18.8
Switzerland	2	6.4
Other countries	176	15.0
Total	2,061	....

1. Based on total number of neuropsychiatric cases from each country.

TABLE NO. 16b

State of Birth of Native-born Mental Defectives

State	White	Colored
Alabama	435	711
Arizona	2	0
Arkansas	392	185
California	180	1
Colorado	69	1
Connecticut	83	4
Delaware	17	10
Florida	136	20
Georgia	504	181
Idaho	23	0
Illinois	660	16
Indiana	401	9
Iowa	275	2
Kansas	201	6
Kentucky	856	83
Louisiana	280	338
Maine	174	0
Maryland	374	281
Massachusetts	229	3
Michigan	423	4
Minnesota	231	0
Mississippi	318	391
Missouri	922	55
Montana	11	0
Nebraska	124	0
Nevada	7	0
New Hampshire	36	0
New Jersey	279	7
New Mexico	207	0
New York	814	12
North Carolina	641	187
North Dakota	49	0
Ohio	778	17
Oklahoma	189	52
Oregon	39	21
Pennsylvania	1,056	24
Rhode Island	38	3
South Carolina	304	259
South Dakota	94	1
Tennessee	623	448
Texas	421	113
Utah	36	0

TABLE NO. 16b—concluded

State of Birth of Native-born Mental Defectives

State	White	Colored
Vermont	36	1
Virginia	575	280
Washington	42	0
West Virginia	370	15
Wisconsin	317	0
Wyoming	3	0
District of Columbia	13	35
Total ascertained	14,287	3,776

TABLE NO. 17

State of Residence of Mental Defectives

State	White		Colored	
	Number	Per cent[1]	Number	Per cent[1]
Alabama	397	36.0	656	66.4
Arizona	18	15.0	1	0.0
Arkansas	384	43.7	231	62.4
California	377	22.0	5	14.3
Colorado	120	24.8	0	0.0
Connecticut	163	26.7	6	0.0
Delaware	21	22.8	15	37.5
Florida	152	31.1	15	11.5
Georgia	511	33.3	141	31.7
Idaho	44	26.7	0	0.0
Illinois	791	19.9	60	41.0
Indiana	417	23.3	14	32.6
Iowa	239	25.3	3	12.6
Kansas	197	21.6	11	21.6
Kentucky	771	41.1	67	38.5
Louisiana	275	28.8	332	48.3
Maine	202	51.5	0	0.0
Maryland	396	44.9	319	74.4
Massachusetts	400	25.7	7	33.3
Michigan	623	29.2	15	32.6
Minnesota	262	22.2	1	0.0
Mississippi	308	35.4	328	44.6
Missouri	922	33.8	68	24.4
Montana	45	16.7	1	0.0
Nebraska	125	25.1	1	0.0
Nevada	11	18.3	0	0.0
New Hampshire	38	27.7	0	0.0

TABLE NO. 17—concluded

State of Residence of Mental Defectives

State	White		Colored	
	Number	Per cent[1]	Number	Per cent[1]
New Jersey	393	27.5	13	21.0
New Mexico	94	41.4	0	0.0
New York	1,271	19.9	47	29.2
North Carolina	651	46.7	154	40.8
North Dakota	101	38.5	0	0.0
Ohio	901	23.9	57	33.5
Oklahoma	398	33.3	95	57.9
Oregon	55	18.1	0	0.0
Pennsylvania	1,522	27.0	119	42.0
Rhode Island	65	29.2	4	40.0
South Carolina	318	43.4	219	40.0
South Dakota	101	33.1	0	0.0
Tennessee	570	43.0	501	71.8
Texas	414	25.5	114	33.4
Utah	31	20.5	0	0.0
Vermont	38	33.6	1	0.0
Virginia	656	45.5	280	48.6
Washington	115	26.1	2	0.0
West Virginia	469	38.6	30	37.5
Wisconsin	363	27.0	1	0.0
Wyoming	25	21.8	0	0.0
District of Columbia	26	16.1	48	52.7
Unascertained	1,017	....	73	....
Total	17,803	29.2	4,055	48.3

1. Based upon neuropsychiatric totals for each state.

TABLE NO. 18

State of Residence of Foreign-born White Mental Defectives

State	Foreign-born mental defectives
Alabama	0
Arizona	3
Arkansas	1
California	85
Colorado	16
Connecticut	76
Delaware	4
Florida	5
Georgia	4
Idaho	2

TABLE NO. 18—concluded

State of Residence of Foreign-born White Mental Defectives

State	Foreign-born mental defectives
Illinois	138
Indiana	15
Iowa	6
Kansas	7
Kentucky	2
Louisiana	1
Maine	29
Maryland	12
Massachusetts	160
Michigan	167
Minnesota	34
Mississippi	4
Missouri	18
Montana	7
Nebraska	12
Nevada	2
New Hampshire	5
New Jersey	92
New Mexico	6
New York	412
North Carolina	0
North Dakota	20
Ohio	107
Oklahoma	5
Oregon	6
Pennsylvania	356
Rhode Island	32
South Carolina	0
South Dakota	9
Tennessee	0
Texas	10
Utah	6
Vermont	3
Virginia	5
Washington	24
West Virginia	11
Wisconsin	49
Wyoming	3
District of Columbia	1
Unascertained	89
Total	2,061

CLINICS FOR MENTAL DEFECTIVES IN THE STATE OF NEW YORK

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NO one who is well informed doubts the wisdom or even the necessity of providing clinics for those suffering from nervous and mental disease. Such facilities, particularly as out-patient departments of hospitals for the insane, have been in existence for years throughout New York State. It is only within the past year, however, that any attempt has been made to provide similar state-wide clinics for mental defectives, and the importance and the purposes of such clinics have yet to be shown to many who should be interested, but are indifferent.

A study of the extra-institutional aspect of mental deficiency alone should be sufficient to indicate the need for clinics. Based upon the findings of the neuropsychiatric medical officers in the army, it is estimated that there are about 40,000 mental defectives in New York State outside of institutions, there being state and municipal institutional accommodations for about 6,000, a condition that is much worse in many other parts of the United States. One of the best means of reaching these mental defectives, as yet largely unidentified, is the clinic, through which some effective supervision and other provisions may be instituted.

It is the purpose of this paper to outline the methods of organizing and conducting clinics for mental defectives in New York; also the objects of these clinics, the types of cases with which they deal, and what they may accomplish. A few very excellent clinics in metropolitan districts are not included in this discussion, not being a part of the state-wide plan.

In many communities there is a needless duplication of out-patient facilities, resulting in a waste of space and effort. The present plan is the result of a tendency in New York towards consolidation, and has as its ultimate object the es-

tablishment of "health centers" throughout the state, combining all varieties of clinics.

Over a year ago, there began to be in New York considerable agitation for state-wide coöperative clinics. At least seven state organizations were found either already actively engaged in clinic work or definitely interested in having such facilities made available. An informal Committee on Joint Clinics was formed, consisting of representatives of the State Hospital Commission, the Commission for Mental Defectives, the State Department of Health, the Department of Education, the Board of Charities, the Commission of Prisons, and the Parole Commission. This committee was to meet monthly in an advisory capacity, considering especially ways and means of coöperation.

At the very beginning, the Commission for Mental Defectives decided to use as a basis for the clinics those conducted by the state hospitals, which, to the number of about thirty, were already quite firmly established. This plan was deemed desirable, not only from the standpoint of economy and efficiency—there being no funds for independent work and the personnel available being limited—but also because there is a close relationship between mental deficiency and other neuropsychiatric problems. Defect is often associated with functional or other organic nervous and mental conditions, behavior difficulties and maladjustments frequently constituting an important part of the problem. In fact, in most if not all considerations of mentally defective persons, it is essential to study the physical conditions, the personality, the behavior or type of reaction—in other words, the neuropsychiatric aspect—as well as the educational and psychological phases.

So far as personnel is concerned, there are three types of clinics. In the first, the state hospital furnishes a psychiatrist and a social worker to attend to cases of nervous and mental disease, and the Commission for Mental Defectives a physician experienced in mental deficiency and a psychometric examiner. In the second type, the state hospital provides the psychiatrist and a social worker, the commission only a psychometric examiner, the one physician acting as consultant in all cases. In the third type, the state hospital physician and the social worker attend to all cases, there being no ad-

ditional personnel from the Commission for Mental Defectives. The medical consultants in mental deficiency are supplied by the state schools, of which only two of the four are sufficiently manned to spare physicians for this purpose. The psychometric examiners are secured from the State Board of Charities. The commission itself occasionally supplies a physician and a psychologist.

These various types of clinics, of which the first is preferable, have become established owing to peculiarities of local conditions or lack of sufficient personnel. The ideal clinic should also have stenographic and other clerical assistants, but for the present the notes taken at each clinic are transcribed after those conducting the examinations have returned to their respective institutions.

Most of the clinics have all-day sessions once a month, several, however, meeting weekly. More frequent sessions, while highly desirable, are at present impossible, owing to limited personnel and the travel involved. It is hoped that there will be a gradual approximation to the ideal in "a health center," a clinic available for consultation at all times, with some competent person in charge as secretary to interview all applicants and refer them to the proper clinic.

Clinics are held in a variety of quarters, the most common being rooms in a general hospital, usually consisting of a reception room and two or three examining rooms, assuring the privacy and quiet necessary for an effective interview. In several localities there are "health center" buildings, generally private houses turned over to health authorities and fitted largely for venereal, dental, and tuberculosis cases. Several of these are also used for the joint clinics. Other quarters are rooms in the district or visiting nurses' offices, the community-service building, and, as a temporary expedient, the council chamber of a city hall. Ultimately, it is expected that there will be in community centers specially designed and equipped buildings for the "health centers" already mentioned, where all clinic facilities may be concentrated.

Publicity is an important factor in the success of the clinics. The State Charities Aid Association has rendered valuable assistance in the preparation and distribution of news articles to local papers, describing the objects of the clinics and urg-

ing the public to take advantage of the facilities offered. Personal letters are also sent out to those who should be interested in referring individuals to the clinic. Such letters are written to school superintendents, physicians and nurses, judges, commissioners of charity, social workers, and the like. In inaugurating the work in a new community, a public meeting is often advisable for arousing general interest. A neglect of publicity means a corresponding lowering of interest in the clinic.

The commission is also prepared to hold emergency clinics in localities not convenient to the regular stated clinics. A possible development is a "flying clinic," one constantly on the road and available for rural communities.

Quite contrary to a rather common erroneous idea, the clinics for mental defectives are not designed primarily as means of adding to the population of institutions. In the first place, they are available for purposes of consultation and advice in cases referred for examination from the schools, courts, and other sources. Paroled cases also report here for observation at regular intervals. Secondly, the clinics are used for interviewing the relatives or responsible friends of mental defectives and instructing them as to proper care and procedure. It is often found that a better understanding by the relatives of the personality and limitations of a mental defective, or a change in the environment, is all that is needed to make commitment to an institution unnecessary. Thirdly, it is the duty of those conducting the clinic to classify and record the essential data. A complete record of the history and examination is retained for use at the clinic, certain statistical data being furnished the Commission for Mental Defectives on cards provided. In short, the clinics should function so as to add to the possibilities for extra-institutional care rather than to act as receiving stations for candidates for admission to institutions for custodial care.

A brief consideration of the types of cases encountered shows the wide scope of these clinics and the unusual opportunities that they afford. As one might expect, a large proportion of the cases have quantitative or intellectual defects as demonstrated by psychometric examination. In many instances, however, this quantitative defect does not constitute

the sole problem. There are often associated either evidences of maladjustment and antisocial behavior, which are the most troublesome features, or physical conditions that might of themselves result in a certain amount of retardation. Truancy, pilfering, a tendency to assault, sex offenses, and the like are among the behavior abnormalities that comprise a goodly share of the problem.

From a physical standpoint, aside from actual brain defect or injury, many of the cases, especially children, present symptoms which encourage one to expect favorable results if proper treatment is instituted and followed. Numerous cases of malnutrition are found to which apparently the backwardness in school work is more or less due. It is astonishing how many mothers are ignorant of the first principles of what constitutes nourishing food. Cases of disorder of the thyroid and other glandular conditions present a most hopeful field for therapy. Children with defects of sight and hearing are often considered intellectually defective until this handicap is removed. Many other physical conditions will be met with, from the common disorders due to enlarged tonsils and adenoids or neglected and infected teeth to the ever-serious constitutional effects of congenital or acquired syphilis. In no case of alleged mental deficiency, therefore, should a physical survey be neglected, in view of the possible indication for medical attention.

An extremely interesting group is composed of cases that are apparently normal intellectually, but that present temperamental defects of such seriousness that it is difficult or impossible for them to adjust themselves to ordinary life. Such individuals—so aptly termed "social defectives" by Dr. Pearce Bailey—are potentially the psychoneurotic, psychopathic, and psychotic associated with various problems of delinquency. While they are difficult subjects of advice, they are most satisfactory when successfully treated.

Neurotic children, suffering from the effects of a faulty home environment, unhygienic surroundings or habits, afford an opportunity for accomplishing much good, provided the parents can also be reached and successfully advised. Such "nervous" children are often brought to the clinic under a

mistaken idea that their various abnormal manifestations are due to mental defect.

In connection with the types encountered at the clinics, it is interesting to consider the practical reasons for having these cases examined, as shown by an analysis of the first ninety-five. About one-half were presented because they were seriously retarded in school work. The question arose as to the cause, and if this proved to be mental defect, what should be done. In practically all the school cases referred to the clinics, there was some degree of mental deficiency. More or less continuous disorderly conduct, amounting in some cases to serious delinquency, was the important feature in over one-fifth of the cases. In about one-twelfth of the cases, evident subnormal physical condition of some kind, associated with apparent mental defect, had resulted in a recourse to the clinic. Several children were presented for an opinion as to whether or not they were suitable for adoption. The question of improper guardianship entered into a number of cases, advice being sought as to possible institutional care or other disposition.

Only about one-twelfth were sixteen years or older chronologically, the greater number, therefore, being of an age more suitable for training. Over 50 per cent were of the moron or higher border-line grades, a fact equally promising of favorable results from training.

The question as to what shall be done in the individual case is often difficult. Inasmuch as the function of the clinic is especially in the line of extra-institutional care, only those cases are recommended for admission to the state schools which are most urgently in need of custodial care or training of a sort that cannot be otherwise provided. Continued delinquency and uncontrollable antisocial behavior, improper guardianship that cannot be corrected, or extremely low-grade mentality are among the reasons for the necessity for custodial care.

Favorable cases are recommended for assignment to special classes in the public schools, where physical and vocational training, correction of speech defects, and so on, are carried out. All children who by any chance might improve under such training should have the benefit of special classes. In

view of the importance of these facilities, it is deplorable that there is such a lack of special classes throughout the state, especially in the rural communities.

Graduates of special classes, those sixteen years old or over and no longer subject to such supervision, or other cases deemed qualified are, through the clinic and after investigation by the social worker, returned to their own homes or placed in other homes. At the present time, there are no well-organized state-wide parole facilities, so that the clinic physician is able only to recommend this procedure, leaving to those personally interested in the mental defective the actual working out of the plan. In this way, mental defectives may be given a chance to make good as workers under circumstances in which many become partially and sometimes wholly self-supporting. The ability of mental defectives in suitable industries has been repeatedly demonstrated. During the labor shortage incident to the World War, many mental defectives, especially of the moron grade, were effectively employed in the simpler factory and ordinary manual work. Forms of labor calling for little skill, but much repetition are peculiarly suited to mental defectives. There is an increasing demand for workers in domestic service, farm labor, and the like, occupations in which mental defectives are often successful under proper supervision. The finding of suitable forms of employment, therefore, is not only extremely important for the welfare of the mental defective, but also meets an economic demand in the community at large.

There are at present ten joint clinics. The further extension of clinic facilities is seriously impeded by a number of lacks and defects in the available machinery.

Summary

1. Although there has been an increasing appreciation of the problem of mental deficiency, there is still an extensive lack of knowledge and interest in this subject. Probably this represents the fundamental cause for the existence of the definite needs enumerated in the following paragraphs. The education of the public as to the meaning of mental defect and what can be done to relieve the situation should therefore be continued and extended by various forms of propaganda.

2. Funds must be provided for the establishment of the clinic facilities on a firmer basis. This will mean ultimately health centers open at all times, with a competent secretary in charge.

3. Available personnel must be increased—i. e., physicians experienced in neuropsychiatry, psychologists, social workers, etc.

4. State institutions must be enlarged so as to accommodate all cases requiring custodial care.

5. State institutions must be better prepared to afford temporary training with a view to the return to the community of many mental defectives industrially equipped.

6. Special classes must be more widely established in the public schools.

7. A state-wide system of parole supervision must be devised for the so-called graduates of special classes and others not under the control of the schools.

AFTER-CARE FOR THE NARCOTIC-DRUG ADDICT*

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MY observation and experience as a deputy commissioner in the district including the city of Greater New York, under the Department of Narcotic Drug Control of the State of New York, has convinced me that our previous attempts to deal with conditions that menace the youth of our city, state, and the country in general have been futile, and that the time has come to utilize this dearly bought experience. I shall review as briefly as possible the steps leading to the present situation.

As many of my readers know, an emergency precipitated by a raid of the federal authorities under the Harrison Act in the city of New York, April, 1919, threw about 2,000 addicts on the public for relief because of the arrest of the trafficking physicians and druggists through whom these addicts obtained their drug. This emergency was met by establishing the Narcotic Clinic, 145 Worth Street, under the City Department of Health. Shortly after the clinic was started, the State Department of Narcotic Drug Control ordered compulsory registration for the First District, which includes the city of Greater New York. As a result of this situation there passed through the Narcotic Clinic during the period of its existence, from its opening in April 1919 to its discontinuance in March 1920, more than 7,700 registered cases of drug addiction. From 700 to 1,000 cases were treated daily, although in periods of special emergency as many as 2,200 were treated in a single day.

By the time the Narcotic Clinic was closed by the City Department of Health, it was an admitted failure. It was opened in the first place to meet an emergency, with no definite plan, but with the hope that it would have a certain experi-

* Read before the Eleventh Annual Meeting of the New York State Conference of Charities and Correction, Aldermanic Chamber, New York City Hall, May 25, 1920.

mental and educational value, which proved to be true. While it was known that a large number of addicts were obtaining morphine, heroin, and cocaine through peddlers, and through trafficking physicians and druggists, the number was indeterminate. The only method of treatment permitted by the facilities at hand was the so-called ambulatory treatment—the giving of a narcotic drug into the possession of an addict for self-administration. The consensus of opinion among all those who have given careful study to the problem of drug addiction condemns this method, as is brought out clearly in the report of the Special Committee on the Narcotic Drug Situation in the United States, appointed by the American Medical Association. The large number of repeaters who came to the clinic and the lack of facilities for commitment gave strong support to this view.

It was hoped that the Narcotic Clinic would become a clearing house for the municipal short-term hospital at Riverside. But although the successful reductive treatment used in the hospital demonstrated convincingly that taking the addict off the drug can be a simple and safe process, as it was effectively administered to 2,300 addicts, it was found difficult to induce the addicts of their own free will to take the treatment. Fewer than one-third of those registered at the clinic took the cure. Worse than this, in spite of the great cost in public monies—around $200 per addict, with a total cost of nearly half a million dollars—about 90 per cent of the hospital discharges went back to the drug because of the lack of scientific aftercare. When we add to this direct cost to the city the fact that many of those who went to the hospital gave up their positions to do so, while others secured leave of absence for five or six weeks, the economic loss with no permanent improvement of condition is seen to be a serious matter.

At the present moment, with relatives of supposedly cured addicts asking for an explanation of their relapses and with many addicts pleading for another chance, the outlook is discouraging. The clinic is closed; Riverside is now opened to a very limited number and as a result of experience refuses to take relapsed cases; the Metropolitan Hospital refuses drug cases; Bellevue has closed its drug ward. It would seem that the only place to which to send a drug addict is the workhouse

or the penitentiary. From the standpoint of enlightened common sense as well as from that of humanitarianism, some other provision should be made for boys and girls averaging twenty-four years of age. A brief statement of the special problems involved in some of these cases will convince one that a solution must be found.

1. M. R. was a youth of nineteen who had become a drug addict through the influence of an older brother. He was sent by the department to a private physician, who wrote of the case: "I have telephoned every possible place where I thought he might be taken care of and find the same answer—they cannot take him because he is an addict. This is further evidence of the necessity of there being some place to send these desperate people. He has a serious heart lesion." This boy died without special care for his affliction because there was no place that would receive him. Drug wards and Riverside Hospital will not take cases of cardiac drug addiction, nor will general hospitals receive cardiac drug-addict patients.

2. The case of B. C. was disclosed through a suit brought by his mother against a druggist, the basis of the suit being the ruined health and loss of services of the boy. Prolonged indulgence in the drug had resulted in demoralization, including jail sentences. It was said that at eighteen the youth was of good physique, excellent character, and fair ability. Within three years he had reached a stage of addiction in which he purchased 300 tablets a week, while in one exceptional week the figure reached 1,000 tablets. He had become a physical and moral wreck, and at the time of the trial of the mother's suit against the druggist, he was brought to the court from jail, where he was serving a term for petty larceny.

3. The case of C. D. is that of a young boy, agreeable and dutiful in his home. When taken to his mother's room to greet a baby brother, he began to weep bitterly. When his mother asked the reason for his tears, he sobbed: "Mother, I am one of those things they call dope fiends." Although shocked, the mother made immediate provision for treatment in a private sanitarium. As soon as he was released, however, he returned to the drug.

4. The mother of F. M., an addict of seventeen, brought the boy to the department in a destitute condition, with the complaint that he was a physical wreck and unable to keep a position. In the examination it developed that the boy had been earning $10 a week, which he had given to his mother, a supposedly respectable woman, while at the same time he spent $8 a week on drugs. Under questioning, he confessed that he stole, and that his mother was not only cognizant of his thievery, but taught him methods of theft in cutting the handles of women's bags and around bargain counters.

Such cases show only too plainly, not only the blindness of society to the situation, but the criminal complicity or indif-

ference in the home. There are many cases in which mothers will plead to have their wayward sons committed to a correctional institution when they go back to the drug and refuse to work, but who do not put in an appearance when the time for commitment comes. Even the family physician is often blind to the actual condition, and will sometimes assist the family for a time to conceal the situation by prescribing for a parent—sometimes addict mothers of infants—or for a youth or young girl. There is hardly a religious community in the city but has a welfare committee. Is it recorded anywhere that the drug addict is included in groups to be advised, warned, or helped? What contribution has any civic organization or woman's club made to the fight against this social menace?

I trust I have made clear the present situation of the drug addict. In the period of interest following the attempts to enforce the Harrison Act, time, attention, and energy, together with a large financial outlay, were expended on the ambulatory treatment of the clinic, a proved failure, or on a shortened hospital treatment which cured the addict, but from which he relapsed on a speedy return to his old environment. Experience has abundantly demonstrated that taking the addict off his drug, while an important step, is only the first step or first aid. The most necessary part of the reconstruction process—follow-up work or, in other words, after-care—has been wholly neglected.

Our duty is clear. Classify drug addicts, as Dr. E. Eliot Harris so strongly recommended in his report at the New Orleans meeting of the American Medical Association. Separate the criminal from the feebleminded, the feebleminded from the social misfit and the otherwise normal. Such a scientific classification is now the enlightened method of attack on all deep-seated social problems. The problem of narcotic-drug addiction calls for study by the great foundations equally with the problem of alcohol or of tuberculosis.

The established necessity for prolonged after-care of the narcotic sufferer away from the old environment with its constant incitement to relapse indicates that his ultimate welfare can best be served by the colony plan, for which abundant precedent is found in this state, famous for such institutions

as the Craig Colony for Epileptics and Letchworth Village. City, county, and state have well-worked-out plans for the distribution of the financial burden of such institutions, a notable case being that of the Hospital for the Treatment of Incipient Pulmonary Tuberculosis.

An old and well-known colony site is available for the use of the Narcotic State Department. Plans are well under way to turn over to the care and cure of the drug addict the beautiful and well-equipped Shaker village of Lebanon, New York, where a thorough application could be made of the methods of hospital, convalescent home, industrial community, and vocational training school. The organization of this project would be in the hands of a supervising medical board, experts on mental and occupational therapy, and recreational leaders.

The Mount Lebanon Shaker village is situated at an altitude of from 900 to 1,200 feet in Columbia County, New York, on the western side of the Berkshire Hills. Drainage is west and north, with a soil good for grain, potato, and fruit raising. The hills and high pastures are excellent for cattle and sheep. The buildings of the community, situated along the highway, have facilities for nearly every trade known to the industrial world—weavers, spinners, tailors, tanners, curriers, shoemakers, blacksmiths, machinists, masons, carpenters, tinsmiths, furniture makers, and manufacturers of medicine. There are bakeries, laundries, and dairies. One building has been used as a chair factory. There are well-equipped barns, poultry runs, an ice house, a granary, and bee houses. A building seating 300 could be used for motion pictures. The houses have in many cases running water, baths, and toilets, closed plumbing, kitchens, bakeries, etc., and can accommodate about 1,000 persons. This condensed description of a survey made by Dr. Arthur L. Shaw, of Mount Lebanon, for the Surgeon General of the Army shows an almost ideal colony for the rehabilitation of the drug addict.

Under the plan for commitment of drug addicts, this colony can be used for the permanent reclamation of these unfortunates. After the addict is taken off the drug, he will be placed under the observation of experts for classification. For those who are found to be true defectives, the colony will not be the proper place, as institutions are already in existence

for the care of mental defectives, where they are segregated and made as useful as possible. Among the correctional cases there will probably be worked out certain subclasses. Those who are "true" criminals will be sent to other institutions. There will also be border-line mental cases which can be industrially reclaimed and returned to the world if kept under the supervision of a wise probation system. There are other correctional cases which are correctional because of their drug addiction, as is shown by the cases I have cited earlier in this paper. It may prove wise to keep them in the colony. The true cases for this colony life will be found among the social misfits, who will find here their great chance to make the start in life that they never had, under such direction as will assist them to find their proper place. Such a life will also be of the greatest benefit to those who are normal except for their drug addiction. In such wholesome surroundings and away from the strain and the environment that have caused their addiction, they have a chance for an enforcement of the will that may return them to the outside world the wholly normal and useful members of society they are without their drug.

It is with great pleasure that I close this paper with a plan that will seem to my readers feasible and practical, and that, if properly put in practice, will indicate that we have learned from the mistakes in our early dealings with the drug addict that our great mistake was we did not go all the way. We have learned that we must not only take him off the drug; we must, by a system of therapy both physical and mental, remake his reactions to his environment. This is best accomplished by taking him away from the old environment during the period of rehabilitation. In addition the misfit must receive a too-long-delayed economic education, or reëducation, to make him of value to society. There is reason to be hopeful that the addict normal except for his addiction may also respond to the stimulus of proper care and sympathetic study by such a reënforcement of his power over himself and his environment as to return to his normal life a wholly normal person.

DISCIPLINARY MEASURES IN THE MANAGEMENT OF THE PSYCHOPATHIC DELINQUENT WOMAN*

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A PSYCHOPATHIC person is one whose outbursts are due to disturbances of balance, limitations of development, childish psychic life, infantilism of emotions, rather than to mental inferiority or a definite psychosis. Kraepelin says: "The weak points of their *anlage* offer poorly protected points of attack for the injuries incident to the struggles for existence." He gives different types as follows: the excitable, the unstable, the impulsive, the eccentric, pathological liars and swindlers; but he says that the types merge into one another. There are no sharp lines of distinction, no characteristic pathological symptoms; all the different individual disturbances are found repeatedly, sometimes more strongly, sometimes more weakly expressed.

In the excitable, often a very slight cause, such as a simple reprimand, the denial of a wish, or some bit of gossip, may be sufficient to bring about an attack of rage with acts of violence, outbreaks of despair or anxiety, sulky irritability, or obstinate inacessibility. A frequent change of the emotional tone, from external or internal reasons, shows a sensitive, fickle nature.

The emotional background of the unstable is gay and conceited, subject to strong variations; confidence alternates with pessimism or sullen defiance. Their increased feeling of importance, combined with irritability, makes them contentious, intolerant, peevish. Temporary variations in the emotions appear with or without ascertainable cause. They are easily led.

The impulsive are markedly irritable. By far the most severe disturbances are those of conduct, which spring from

* Read before the Mental Hygiene Division of the National Conference of Social Work, New Orleans, April 20, 1920.

impulsiveness of will. We here find three types of impulsive patients—spendthrifts, wanderers, and dipsomaniacs.

The queer show no inner unity or logic in their mental life. Judgment is distorted and narrow. They are sensitive, become excited by petty events, fall into rages, are insulting and threatening. They may show an effeminate sentimentality, have dejected moods, seek solitude. They are difficult to handle, not open to influence, capricious and peevish.

In the liars and swindlers, we find instability and lack of purpose. Their excessive gayety may be interrupted by anxious depression or deep despondency. Nearly all patients are sensitive, easily excitable, and peevish.

The attitude of the antisocial is based on moral bluntness; their emotional relations to their environment remain undeveloped. They lack all those motives of conduct which spring from sympathy with their fellow men. They have no thought of the future, are egoistic, brutal. Their emotional tone is quite often gay, self-conscious, occasionally haughty, but also gloomy, depressed, or anxious. It changes quickly and without evident cause. Very often there exists a strong irritability which may lead to outbreaks of great violence; the patients threaten, insult, and are at times ready with knife and revolver.

In women, the majority of the emotional storms occur between the fifteenth and the twentieth year, the number decreasing rapidly from twenty to twenty-five and still more so after this. The age of incidence of this disturbance coincides very closely with adolescence. The great majority of Kraepelin's patients among the liars and swindlers were between twenty and thirty. The women averaged younger than the men.

Nissl, in two cases of congenital moral insensibility, both of whom committed murder and were executed, was able to demonstrate chronic changes in the cortical cells, an indication that those whom we have looked on, not as suffering from mental disease, but only as morally depraved may be suffering from pathological processes in their brains.

Only in exceptional cases may one expect improvement of the antisocial disposition after the twentieth year. The majority of patients alternate between prisons and hospitals for

mental disease, with short intervals of freedom and criminal activity.

All these patients are passionate, sensitive people, who become excited over some petty detail. They accept every opposition as a personal matter. The contentious are characterized by an uncommon tenacity of emotional tension in which every stimulus continually finds new sustenance and influences thought and conduct, and every insignificant friction arouses endless bitter strife. Permanent withdrawal of freedom acts very badly on the patient.[1]

Kraepelin has given us here the characteristics of the psychopathic woman, her everyday working disposition in normal life. In the delinquent psychopath, these characteristics are aggravated and magnified. Her own uncertainty as to whether or not she can help her outbursts is intensified. She always hopes that she is not so odd and unlike her fellows as she suspects she is. In community life she thinks she bluffs it through; as a prisoner she knows she does not, and worst of all she knows that you know she does not. In desperation she shrieks at you, "I'm just as good as you are!" It is a defense reaction. You may spend hours, days, nay weeks, trying to help her to hold on to that truth. She is right, because it is not a question of goodness or badness; it is a question of outbursts due to psychopathic personality, a confusion which is the crux of the whole problem in considering the disciplinary measures suited to such women as she. A reformatory sentence puts the emphasis on conduct and crime and a stigmatized life, and weakens her only hope that she may overcome her defects.

Far too little thought is given to what constitutes misconduct or criminal behavior, and whether or not symptoms of disease can be ethically considered crime. We see how ridiculous it would be if we should call night sweats misconduct and forget that they may be symptoms of tuberculosis, or the unsteady gait of locomotor ataxia misconduct instead of a sign of disease.

A frightened public, pleading for protection, and a judiciary untrained in psychiatry commit these people to the strongest, ugliest, most unsympathetic building they can construct, and

[1] The preceding material is a free translation from Kraepelin.

call them criminals! To this the psychopathic personality rebounds like a small boy sitting on a pin. Her conduct says what her tongue has not yet learned to say: people need treatment on the basis of personality defect, not on the conduct manifestations of those defects. She says this, too, in no uncertain terms, as the following case histories show:

Case 1. This is the history of a very handsome young woman who was eighteen years of age at the time of her first commitment to the Massachusetts Reformatory for Women. She is of unusual physical attractiveness and superior intelligence, and is otherwise diagnosed as a psychopathic personality, with episodes closely simulating true hysterical attacks.

She is American born. Her father, a French Canadian, was a hard drinker, never supported his family, and deserted them when the patient was a young child. Her mother was Irish born, industrious and very respectable, but described as an extremely nervous woman, "at times almost insane;" she died when the patient was sixteen. A younger brother has been arrested for larceny of money from his employers.

As a child, she apparently led a very irregular life, owing to the fact of her father's non-support. From her second to her sixth year she was in an institution; then for three years she was at home with her mother; but at nine years she was again placed in an institution and remained there to fourteen, when she was returned to her home because of bad behavior. In a very short time the mother was compelled to send her away again, this time to the House of the Good Shepherd. Here she was so incorrigible that they would keep her only one month. She was then sent to a rescue home in the same city with like result—discharged because of incorrigibility—and at fifteen years was finally committed to a reform school as an idle person. From there she was paroled to live with an aunt, but because she was scolded for staying out nights she ran away, and for some time thereafter worked as an artist's model and later in the ballet of a burlesque show.

She was committed to the Reformatory for Women at eighteen, on the charge of larceny, and her illegitimate child of four months was admitted with her. (The father of this child was a young medical student who would have married her if he had felt that she had been faithful to him.) She was

not noisily troublesome for the first few months of her stay. Then one day she was brought to the institution hospital on account of a salpingitis. At this time it was thought that she exaggerated the pain; she screamed hysterically. After this attack of pain subsided, a few days later, she was told that she must continue treatments such as many of the women were having for gonorrhea. She declared that she was not in the same class as the other women and had no disease such as they were being treated for. That afternoon she had her first attack of apparent unconsciousness, in which she frothed at the mouth and acted as if she might have taken poison of some kind. To rule out this possibility, her stomach was washed out, but nothing was found. Her unconsciousness lasted about one hour. Following this, the attacks occurred one or two a day, lasting from one-half hour to six hours. Then they ceased for a few days, only to return more prolonged and frequent. She became insolent and unmanageable and refused to eat; threatened suicide and was found with a solution of potassium permanganate beside her and stains of it on her nightgown and on her lips. Her stomach was again washed out, but nothing was found. She had written a letter of farewell, saying that she "had to do it."

Her liberty in the hospital was then taken from her and she was put into a room with another woman to care for her. She then had an attack in which she screamed for an hour and a half, while she was in an apparently semiconscious state from which all efforts to arouse her failed. She threw herself about with such violence, following this attack, that it took three persons to prevent her from injuring herself. After this she was quiet for one week and admitted that she had no real intention of taking her life.

A month after her admission to the hospital, she was discharged to work out of doors, at her own request. The following night she had an attack in her room, being found apparently unconscious on the floor. When she came out of this attack, she was very much excited, cursing and abusing the matron whom she found with her. She had finally to be brought back to the hospital, where the hysteroid attacks were resumed, this time accompanied by constant screaming. She threatened suicide several times and once was caught with a

cord about her neck, which was removed with difficulty after her face had become cyanosed. She finally became so uncontrollable that she was transferred to a state hospital for mental disease. Here she is reported to have continued her screaming, to have assaulted attendants, smashed and destroyed property, and in her quieter moments teased the insane women about her.

In about six months she was returned to the reformatory as needing no further treatment at the state hospital. Following this, she gave constant trouble in refusing to obey rules and in inciting others to do the same; she was insolent to the matrons and absolutely refused to do any work which she considered menial. There was, however, no recurrence of the attacks of unconsciousness and screaming, and four months later she was released on parole.

When she had been only a few weeks on parole, she broke it by leaving her place of work, taking with her clothing and money belonging to her employer. Six months later she was returned to the reformatory on revocation of parole. Since breaking parole, she had been living as a prostitute, finally had attempted suicide on the street, and had been taken to a hospital, the officers of which communicated with the reformatory. Two weeks after her return to the reformatory, she was transferred to the state infirmary for an operation (salpingectomy). While there, she was so unruly and unreasonable that the infirmary officials telephoned the reformatory that she must be removed, and she was therefore returned to the institution as soon as it was safe to move her.

On her return, she cursed the receiving matron and began at once to be unruly. She was admitted to the hospital department because of her condition. Here she began her old habits of screaming and cursing—would scream for hours at a time, so that it was impossible for the other patients in the hospital to get any rest. The mothers and babies also, whose corridor is above the hospital, had to listen day and night to her screams. When special appeal was made to her to be quiet for the sake of the babies, her answer was, "To hell with the babies!" She refused to take medicine—threw it violently on the floor when it was offered to her. She was placed in a room as far as possible from the hospital and mothers' cor-

ridor, still being under hospital care, but her screams and banging on her door were still easily heard. She broke the chair in her room and with the pieces succeeded in breaking through the grating of her window. She yelled from her window vile language at any man she saw passing on the street; talked to the women through her window in obscene language and incited them to act badly; took off her clothing and sat naked in her room; would brace herself against the door so that entrance had to be forced when food was brought her; assaulted and reviled the officers, or refused to speak to them or the doctor.

After five weeks of this, she calmed down, but the calm was brief; in a short time she was reported as in an excitable state, cursing and ugly. She made another pseudo attempt at suicide, this time by drinking brass polish; she claimed she had taken a tablespoonful, and then began her screaming again. It took four people to hold her while the stomach tube was passed. Stomach washings showed again she had taken nothing. Following this, there was another period of noise and screaming and escaping from her room. She tore up her blankets and made a rope of them, presumably to strangle herself; placed in the bath, she attempted to go under the water; with pieces of glass broken from her window she made superficial cuts on her wrists. Finally handcuffs were placed on her (locked in front), but even with these on she succeeded in tearing up her skirt, making a string and tying it to the radiator and then about her neck. She broke dishes brought her and refused food; threw food and the contents of her toilet bucket on the matron; spat in the faces of officers and doctor; would watch for opportunity to get past the officer as the door was opened and would run down the corridor and into the rooms, frightening other women. It took several people to get her back into her room, and in the process she would scream out the most vile oaths, spitting and biting. Her most pernicious influence was on the other unstable women, who would answer her songs and calls. Once she called "fire" to create a panic.

There was next a period of comparative quiet lasting almost three months, after which she again had to be placed in the isolation corridor. She screamed, sang, and banged on the door. She dug through the plaster wall into the next room,

broke down the door of this room, and ran into the hospital, screaming that she had taken poison—potassium permanganate again—that she had found in the bathroom into which she had broken; she fell into a semiconscious state again and claimed to have great pain. Another washing of the stomach showed, as many times before, that she had swallowed nothing. She was placed in a fresh room in the isolation corridor, but continued noisy and profane, broke eight panes of glass, and shouted through the window at passersby that she was being murdered, that officers were sticking nails in her feet and scalding her feet and pulling her hair. She shouted the same accusations at the other inmates whenever she saw them in the yard. At this time, she was seen by several visiting psychiatrists, who did not consider her insane. Shortly after their visit, a man from the neighborhood called at the institution to complain that his wife, who was pregnant, was being "driven insane" by the screams of the patient. He said that the neighbors were gossiping; that many wild stories were being circulated about the patient, but the favorite one was that she was a woman seized by the police during a strike in Rhode Island, and that she "got going this way during the strike and could not stop."

She continued alternately quiet and troublesome for a period of several months, when it was finally decided to try the effect on her of transfer to a house of correction. This was done, because she had been wont to say that, if one had to be in jail, the reformatory was the most fashionable place. It is reported that in the house of correction she began her screaming and smashing; whereupon the master promised her that if she stopped, he would see that she was paroled, and in this way parole was voted three weeks later.

This résumé of her reactions at the reformatory simply describes her noisy periods; her periods of quiet, however, were only relatively so—there was never any time when she was not troublesome. Special kinds of work had to be devised for her; she demanded rubber gloves when she was asked to do any work that necessitated putting her hands in water; special privileges had to be given that could not possibly be given the women as a group. The matron under whom she worked at such times was under constant tension. She

was intelligent and attractive and a leader of those about her, although she was on the whole brutal in her comments on the physical and mental defects of those less generously endowed than herself. Her tendency as a leader caused much more trouble than her noisy outbreaks, as it spread her methods among her unstable followers. She attempted—and succeeded in a measure—to start small riots, herself keeping in the background.

Case 2. The next is the history of a girl now twenty-seven years old. She was committed to the state board of charity, after being repeatedly delinquent, at the age of eleven years. Since that time, she has been four years in Lancaster Industrial School and in the School for Feebleminded, and has been treated or observed in five different hospitals for mental disease on seven occasions, spending altogether about seven years in insane hospitals. She had also been tried out at the House of the Good Shepherd before her commitment to the Reformatory for Women when she was twenty-five years old.

She was born in Massachusetts of Italian parents. Her father is considered mentally defective, was in his youth excessively alcoholic, but more recently has been industrious and doing "as near right as he knows how." He is a peddler of fish and evergreens, and is in general law-abiding; and he has been arrested only once for violation of a city ordinance. The mother is described as weak-minded; was unable to learn in school, is so excitable and irritable that she is unable to stand the noise of her children at home and so has always worked in a factory. Both parents are described by court officials as "hard working, but very ignorant—in fact, only a few degrees from the brute."

This girl is the third in a family of eleven children. These children are described by the court of their home city as "a source of annoyance and a nuisance almost as soon as they are brought into the world." All of them are considered mentally defective; all had records in the juvenile court as soon as old enough. Two brothers have long court records and have served sentences in the reformatory and the house of correction on charges of larceny, assault with intent to rob, adultery, drunkenness, etc. Another brother was committed as incorrigible to the state board of charity at eleven years,

and has recently been arrested for drunkenness. Two sisters have been in the juvenile court for larceny. Another sister is said to be very low-grade feebleminded, has been in many institutions, and has had three illegitimate children. Two young brothers have been repeatedly arrested for larceny.

When the patient was eleven years old, she was committed to the state board of charity by the juvenile court, following repeated larcenies. While under the care of this board, she stole repeatedly and was so incorrigible that it was impossible to find a boarding home to keep her. After three months, she was committed to the industrial school at Lancaster. Here she is reported to have been "destructive and noisy; would break anything in her reach when she was ugly, which was most of the time." She is said to have torn a tin plate into strips; tore up her clothing; attacked officers and sprained the wrist of one of them. She was placed out in families several times, but had to be returned because she was persistently out late nights and stole repeatedly. After four months at Lancaster she was transferred to the School for Feebleminded at Waverley. Here she is described as "violent, destructive, and dangerous; would become disturbed over some trivial thing and fly into a rage, threatening to kill the attendant. These attacks became more frequent and in them she would bite, scratch, and kick, and throw stones at any one who happened to be near her." She was kept at Waverley one month and then was transferred to one of the state hospitals for mental disease.

There she was quiet for a short time, but soon became willful and mischievous; was "lazy, refractory, impudent, noisy, quarrelsome, and tricky." After four years in the state hospital she escaped and was almost three years in the community before she was again returned. In this interval she had been living a most irregular life and had given birth to an illegitimate child, which died at two years of spinal meningitis. She was finally returned to the state hospital on complaint of her father, who could do nothing with her. She had refused to work either in the home or outside.

About three years after her return to the state hospital, she was permitted to go home on a Christmas visit, and while being returned to the hospital by her brother, escaped. Alto-

gether, she had spent about seven years in hospitals for mental disease, the diagnosis of the physicians being "defective delinquent." In the next two years, while in the community, she appeared frequently in the Boston courts on the charge of soliciting sailors. She was tried on probation in the House of the Good Shepherd, but was surrendered to the court because unmanageable there. She was sent twice to the Psychopathic Hospital, where she was diagnosed as "psychopathic personality, not insane." She was tried out on probation at home, but three months later was surrendered to the court by her father, who again was unable to control her. At this time she was sentenced to the Reformatory for Women, being then twenty-five years old.

On admission, she was in an ugly, surly mood because she felt that her father had gotten the better of her in having her sent to the reformatory, where he had heard that she would have to work. She boasted of having nearly killed an attendant at Waverley, and said that she would kill some one at the reformatory, so that there would be some real reason for committing her.

From the first, she refused to get out of bed and was unspeakably filthy in her personal habits; she refused to wash even her hands, emptied her toilet bucket on the floor, spat all about the room and on her bed, emptied her mattress on the floor, tore her clothing, decorated her hair with innumerable bows made from her torn sheet, etc. She would sleep during the day, and in the evening, when the other women were in bed, she would begin to sing. Her singing took the form of a chant in which she recited various smutty incidents of her recent career, the recital of each incident closing with an irritatingly constant phrase—"And, O boy, we raised up holy hell!" The chanting was interspersed with loud laughter which was deliberately maniacal in tone, learned, she frankly confessed, at the hospital for the insane and intended to scare those about her, with the idea that she might be transferred to the state hospital. She made screaming threats to kill all against whom she had a grudge, and her language was unspeakably vile. She yelled that the food was poisoned, that the toothbrush given her had poison on it, etc.

Though her behavior was recognized as largely a matter of

malingering, after standing this for twelve days the officials of the reformatory decided to ask for her transfer to the state hospital, since she had been a patient there for seven years and had never been technically discharged. As soon as she knew that she was to be transferred, she became quiet and even pleasant, and was overjoyed because she was "going to get the best of" her father.

At the state hospital to which she was transferred, she had a relatively good record for eight months, and at the end of this time was normally eligible for parole and was expecting it. Toward the close of the eight months' period she began to threaten all sorts of things unless parole were given her, and especially to escape. The hospital then discharged her back to the reformatory as not insane. On her return she was surly, morose, and depressed; insisted that the state had never given her half a chance, that she would do well if given parole like other girls. To help convince her that the state was willing to give her every chance, parole was asked for, although there was no expectation that she would live up to it. As expected, she broke her parole at once; refused to coöperate with the parole officer and swore at her when the latter came to take her home. She was returned in a very short time to the reformatory on revocation of parole.

Immediately on her return she began to simulate mental disease, hoping for transfer to the state hospital again. She swore that she would never do a day's work for the d—— old state of Massachusetts, and took many other very noisy oaths. It was carefully explained to her that, inasmuch as the state now considered her delinquent rather than insane, she should try to conform to the new conditions. Her answer was, "To hell with the state and the whole bunch of you! I am going to yell the roof off this place, so you people will be d—— glad to get rid of me!" She generously carried out her threat, so that we were compelled to try our most rigid forms of discipline on her. She is the only woman in our institution upon whom we have tried apomorphine. She reacted well to this and was quiet for a time. Since then a firm promise that she would be given another injection if she disturbed the other women at night has kept her comparatively quiet.

At no time, however, has she conformed to anything approaching order, or lived up to the rules of the institution in the ordinary sense.

She is excessively lazy, is vain of her appearance without any physical cause, and if permitted will spend hours before her mirror. If she does not happen to like a matron, or becomes irritated with one she does like, she will call the unfortunate woman all the names in the calendar of vulgarity. She has never done a full day's work; has never been able to sleep in the corridors with the other women because of her tendency to nightly disturbances; keeps her room in the receiving ward in a filthy condition. She gets on relatively well for a few days at a time; then, on the slightest provocation—and at times apparently without any provocation at all—she will break out into the most violent abuse of all about her.

We have found her relatively timid physically, in spite of her alarming threats, and she has offered no violence except in words to any who does not show fear of her. We have never found it necessary to repeat the use of apomorphine, and a firm promise to tube feed her if she misuses her food has always had a good effect. Although she has never been tube fed in this institution, she probably has in others and knows the process.

Discipline might be defined as education and training, correction of faults, or punishment inflicted by way of correction and training.

A reformatory has at its command the following resources to carry out the terms of this definition:

1. *For Education*

A. Religious instruction and services, character building, moral training

B. Academic classes, including music and household arts

C. Industrial training, which includes, in the Massachusetts Reformatory for Women, the needle industries, the making of shirts, flags, stockings, laundry, and garden and farm work, on the modern factory basis (the eight-hour day)

D. Playground in summer, indoor recreation in winter (no gymnasium)

2. *For Correction*

A. Moral suasion—i. e., an analysis of the grievance and an earnest effort toward reinstatement

B. Loss of privileges

C. Detention in a choice of four different grades of room (beginning with the patient's own bedroom), each unpleasanter, stronger, and less comfortable than the last, in which to think it over and decide to help and not to hinder, the choice of room depending upon the wish of the patient, the length of stay in any given room depending upon the will of the patient.

The women we are discussing are nonconformists in educational discipline, as you can see. They are not available for consecutive work consecutively. They force onto the reformatory régime a problem all their own; it is not a reform problem. We have not found what treatment they are accessible to in a reformatory, meaning by treatment educational and correctional discipline. When we called in, in consultation, a group of psychiatrists in Case 1, they declared that they had nothing in their profession available and suggested rigorous correctional discipline. But we had learned that correctional discipline did not change the emotional tone of these women, and it intensified their outbursts. We were also convinced that residence in a reformatory aggravated their disease. However, these physicians would not accept our patient on a transfer to their institution, to work out a method of treatment for her.

In a reformatory the régime should not be that of a chronic hospital. Acute cases should be sent there for treatment and cure. To reform means to cure. The psychopathic woman brings with her to the reformatory a chronic condition which cannot even be treated there properly, let alone cured. She knows that she is different from the normal and the feeble-minded prisoners; she knows that she can become their heroine because she is, as they say, "game"—i. e., she does not "give in" to anything you try to do for her. She is, as we see it, the victim of an immoral state policy built up on "the public demand for protection" which persists in sending all prisoners to prison, and does not realize that some of them should be sent to hospitals equipped to treat the underlying *causes* of

their misconduct. They are the victims, too, of indecision among experts because of lack of real knowledge as to what treatment they will lend themselves to. Meantime they are being battledored and shuttlecocked between insane asylums and reformatories, each of which declares that the other is best suited for the disciplinary management of these women, and neither of which is succeeding in managing them.

STATE INSTITUTIONS FOR THE FEEBLE-MINDED

V. V. ANDERSON, M.D.
Associate Medical Director, The National Committee for Mental Hygiene.

THE depredations, the vast expense, and the loss in wasted and frequently vicious human lives growing out of the lifelong dependency and criminal behavior of untrained and unsupervised mental defectives continue to furnish practical arguments for a broad and comprehensive state policy of protection against the burden of feeblemindedness. The extent and menace of this problem, the close relationship it bears to hereditary pauperism and dependency in general, to juvenile delinquency, to adult crime, to prostitution and the like, have been brought out in recent surveys of mental deficiency conducted by the National Committee for Mental Hygiene in Kentucky, Maine, Tennessee, Alabama, Arkansas, Mississippi, and Georgia.

Growth of provision for this class has greatly increased during the past few years, so that now only five states in the Union have failed to make any institutional provision for their feebleminded—West Virginia, New Mexico, Arizona, Nevada, and Idaho. Let this not be understood as meaning that other states are doing their full duty in this direction. Though most states can now be said to have made a beginning in the way of handling this problem, still not a single state in the Union is doing more than touching the surface; vast numbers are as yet uncared for, untrained, unsupervised, and unprotected. "It is safe to say that no state has as yet officially taken cognizance of 10 per cent of the mentally defective persons within its borders; no state has even ascertained their number, their location, or the nature and expression of their defect. The great majority of these defectives receive no education or training and no adequate protection or supervision."

The largest and most urgent need in connection with this

problem is greatly increased institutional provision. The keynote to any and every program of properly handling the problem of feeblemindedness is the institution; around it must revolve all other state machinery. Interest in such institutional provision has become widespread, and during the year 1919, Tennessee, Alabama, Georgia, Florida, Mississippi and Hawaii, not hitherto providing institutional care for the feebleminded, made appropriations for the construction of such schools. Massachusetts, Minnesota, Illinois, Indiana, and Wisconsin appropriated large sums for the construction of new institutions, while South Carolina, Oregon, New Jersey, South Dakota, Nebraska, and other states provided appropriations for the construction of additional buildings.

With this increased program for institutional development, greater care and more serious attention are being devoted to the type of buildings and methods of constructing and operating such institutions. It is becoming increasingly evident that instead of each state's building something entirely new or what seems locally to be desirable and attractive in structure and design, the object should be to profit by the experience of the past and from the knowledge of those who have a practical familiarity with the needs and requirements of the defective, and after a careful study of existing institutions, to combine as far as possible all of their good features, and especially to avoid their defects and inconveniences.

This article, which is essentially concerned with the construction, administration, and operation of an institution for the feebleminded, is the result of a careful study of certain leading institutions for the feebleminded in the United States. It is based upon the splendid work done at these institutions by Fernald, Little, Wallace, Murdoch, Bernstein, Emmerick, Bliss, Haynes, Cobb, Wilmarth, and others.

In the first place, there are certain generalizations about which there can be no difference of opinion. In planning a new institution the following things are essential—ample acreage, proper transportation facilities, adequate water supply, drainage, and sewage disposal. It is well, also, to consider the possibility of a gravel pit, and plenty of clay for the making of brick by the high-grade boys.

Site

In choosing the site or location of the school, accessibility or nearness to large centers of population is particularly desirable; parents are always more willing to permit of the commitment of their children if visiting is made easy. The advantages in the way of clinical opportunities offered by such an institution for the purpose of training teachers for special class work and medical men for diagnostic work in connection with clinics in schools and courts must not be lost sight of.

The amount of land is more or less arbitrarily fixed at an acre per inmate, and the number of acres bought should equal the number of inmates eventually expected. If possible, good farming land should be secured—land adapted to gardening, farming, and dairy purposes. If one is unable to get a fertile farm, sometimes poor farms can be secured and the land improved. It is all right in the rocky sections of our country to buy land that can be gradually cleared up, but wherever possible it is wise to buy land that has good soil. Farming is one of the things that the feebleminded do best, and the per capita cost can be reduced materially if intensive farming is carried on.

Plan

With the site secured, there should be a careful layout of the institution. A complete plan of development should be carefully worked out before the first building is erected. This is necessary because of the underground piping, which has to be extended from building to building; also, to permit of an adequate plan of classification of the children; and finally that the whole may have some relation to the central buildings, such as the power house, administration building, laundry, etc. A topographical map should be kept permanently at hand. Such a map, showing the location of every conduit, pipe, wire, or other underground structure, will prove invaluable.

Layout of Buildings

Such a layout of buildings as the following is customary:

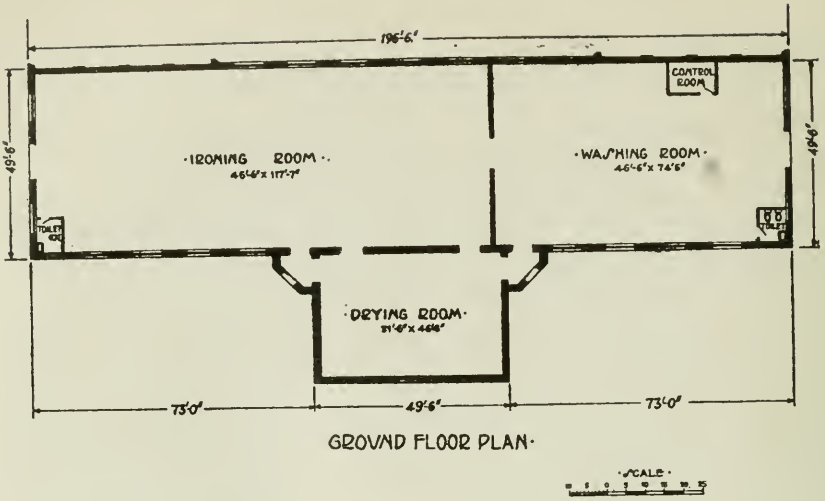
A. Administration building, containing general offices and scientific library.

B. The educational group and assembly hall, containing facilities for grade work, manual training, industries, physical training, and entertainment, such as concerts, dances, movies, and the like. These buildings should be located conveniently to the cottages. The regular carpenter shop should be in connection or in close proximity to the manual-training department, as much of the apparatus can be used for both, and the more proficient children can be graduated into the carpenter shop. Very near at hand a special school garden, small orchard, and chicken yard should be planned for the training in gardening, fruit growing, and chicken raising during the children's school years in preparation for their later activities on the farm and at the colony.

C. Service buildings, containing a central kitchen plant, bakery, store room, cold storage, etc. A discussion of the relative merits of the large congregate dining room as opposed to the cottage-dining-room plan need not be entered into here further than to state that the latter has more points in its favor. The question of greater protection to the children in bad weather and of more individual care and attention from the house mother in feeding, etc., outweigh in my estimation any question of economy that might be offered in favor of the congregate dining room. As regards keeping the food hot, this is a very simple matter, as has been demonstrated at Waverley, Wrentham, and other institutions. The food can be served with perfect satisfaction from the central kitchen by means of specially prepared and properly heated containers.

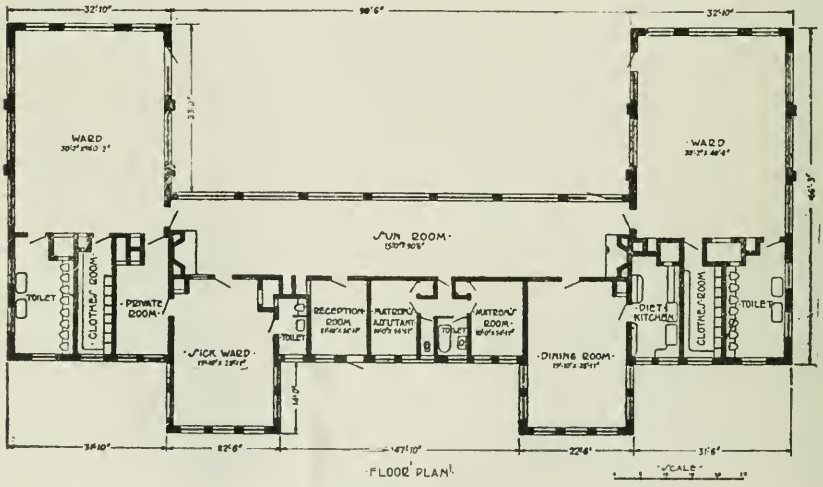
D. Power plant. In this connection the necessity for a completely developed plan of mechanical equipment, light, heat, and power should be emphasized.

E. Laundry. This should be a one-story building. The floor should be on a level with truck or wagon bed so as to avoid the necessity for lifting the baskets up and down. The building should be so arranged that the soiled clothes may go in at one door, be put through the washers, then through the extractors, on through the dry room, into the mangle room, and finally on out through the mending room. The new laundry building at Letchworth Village shown here offers a very satisfactory illustration of the more modern type of institutional laundry.

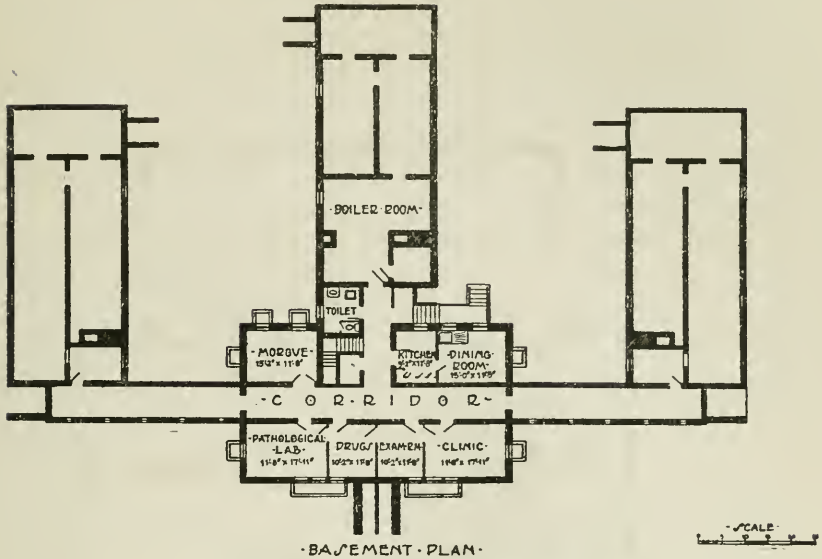


Letchworth Village Laundry.

F. Hospital. The planning of this building is for obvious reasons a matter of considerable importance, and much thought has been given to it by many leading institutional men. Two plans are given below, illustrating general points that need to be considered in constructing a hospital or infirmary building.



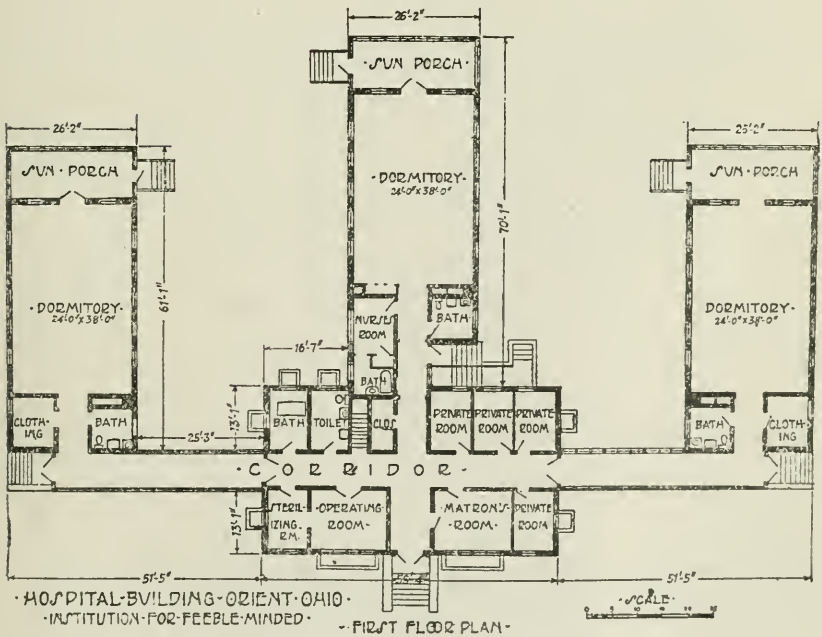
MALE HOSPITAL · WAVERLEY · MASS.
SCHOOL FOR THE FEEBLE-MINDED



BASEMENT PLAN

HOSPITAL BUILDING ORIENT OHIO

INSTITUTION FOR FEEBLE MINDED

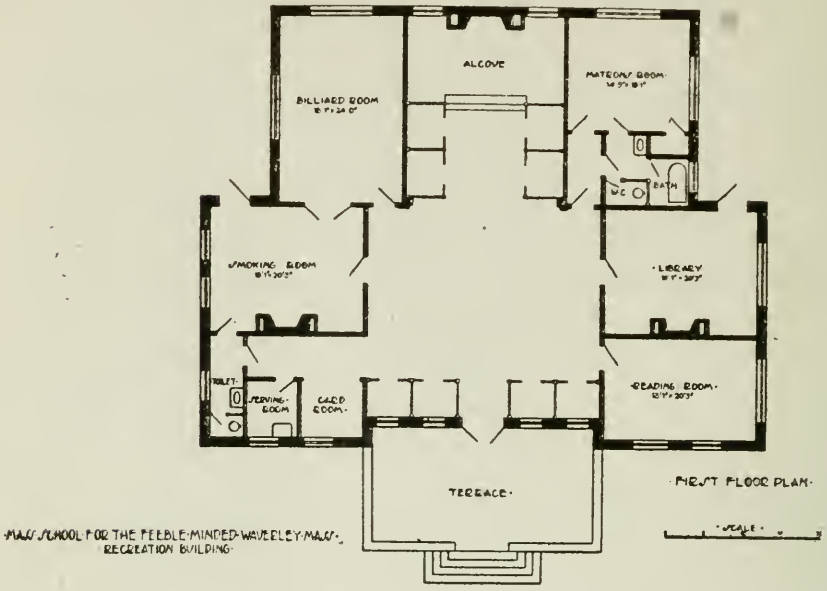


HOSPITAL BUILDING ORIENT OHIO

INSTITUTION FOR FEEBLE MINDED

FIRST FLOOR PLAN

G. Employees' buildings. These should be separate buildings, not only for the housing, but for the recreation and entertainment of the employees. A splendid type of recreation building is shown below. It is the one now in use at Waverley.



The type of construction should be permanent, fireproof, and of whatever material is most economical in the locality in which the institution is situated. This means either brick, stone, or cement. It is well to bear in mind that cheapness of construction, followed by repairs, is costly. In constructing these buildings eliminate unnecessary ornamentation; plan for plenty of air, light, and economy of space, having in mind the suitability of the buildings for their purpose; and reduce the cost to the point where it cannot be criticized by the taxpayer and the business man. We would do well to profit by a study of some of the beautiful and well-proportioned commercial buildings now being erected by certain large corporations, such as the General Electric Company. Around these central buildings at proper distances should be grouped the cottages for the children, making allowances for plenty of space and opportunity for segregating various types.

It can be seen from the above outline that the old-time large central building from which new additions radiate as the necessities of the occasion demand has now become obsolete.

In its stead a villagelike community is being built, with detached cottages of moderate size, of one- or two-story construction, giving opportunity for classification, for separation by sex, for the division of each sex into groups, such as (a) the young and trainable, (b) the infirm, (c) the adult worker, (d) the defective delinquent, etc.

For each group there should be separate buildings of moderate size at suitable distances apart, each cottage having at least one acre of ground.

All of our institutional men are getting away from the idea of handling two or three hundred children in one building. It is a common tendency now to decrease the size and increase the number of buildings in order to secure the proper classification and segregation of different types.

The Cottage

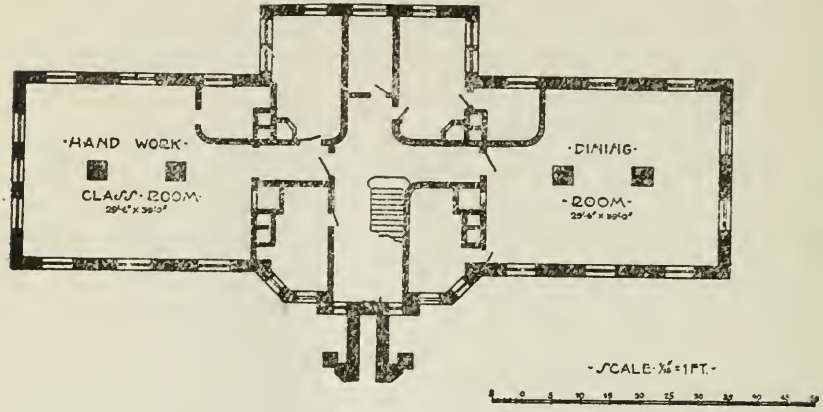
Each cottage should provide for not more than seventy children. It is probably not a matter of great importance whether the cottages are of one- or two-story construction. However, three- or four-story dormitories are now regarded as relics of the darker ages in institutional building. The one-story dormitory can probably be administered more economically than the two-story dormitory holding the same number of children. Feebleminded children can be cared for with much greater comfort and safety to themselves and ease to the attendants in charge in a building free from stairways than in one where steps are necessary.

Each cottage should have a large, light, and airy basement. These basements would not be absolutely necessary if building facilities could be secured for schoolrooms, manual training, industries, and the like. But this is practically always found impossible in the early days of an institution, so that these basements may be used for the entertainment of the children by providing such equipment as bowling alleys, pool tables, etc.

Cement terraces and walks around each cottage are very desirable. They permit of plenty of outdoor exercise for the children in the winter. The cottages should have indirect heating; this insures a good circulation of air, the air being

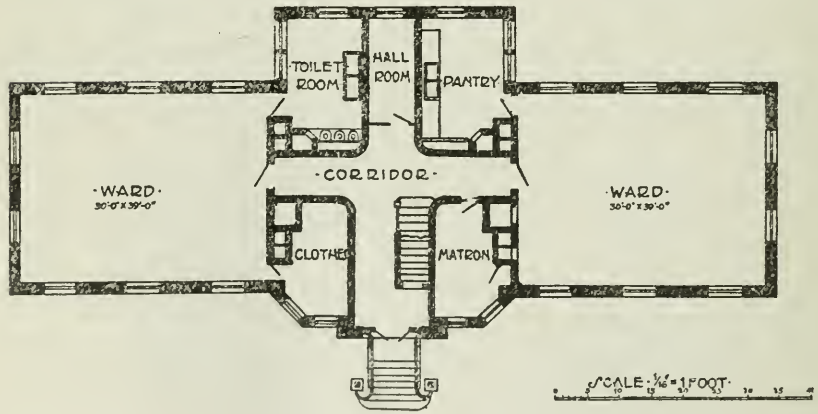
forced in from the outside over the hot coils and into the room. The indirect system eliminates the danger of burns from the radiators.

Below are given plans of typical dormitories in certain leading institutions in this country.



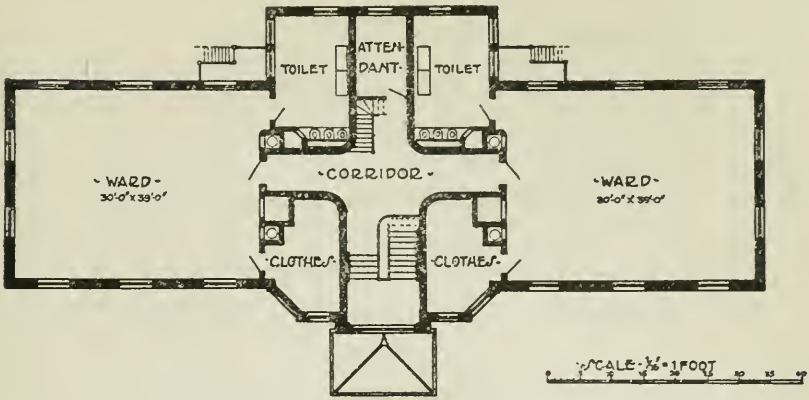
BASEMENT PLAN

MASS SCHOOL FOR THE FEEBLE MINDED



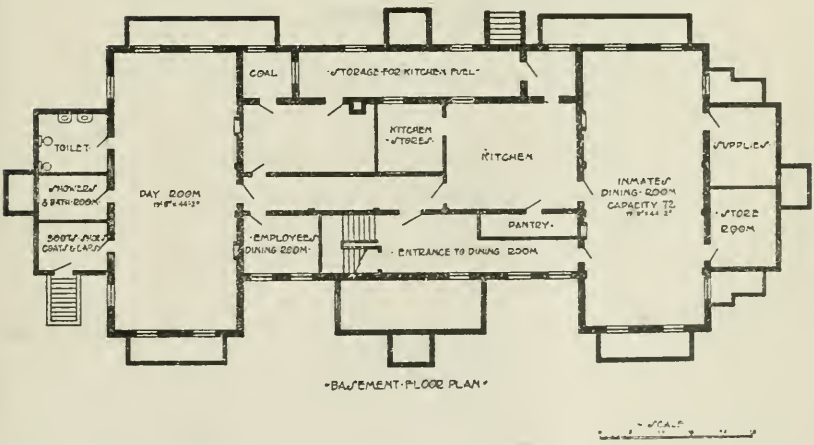
FIRST FLOOR PLAN

MASS SCHOOL FOR THE FEEBLE MINDED



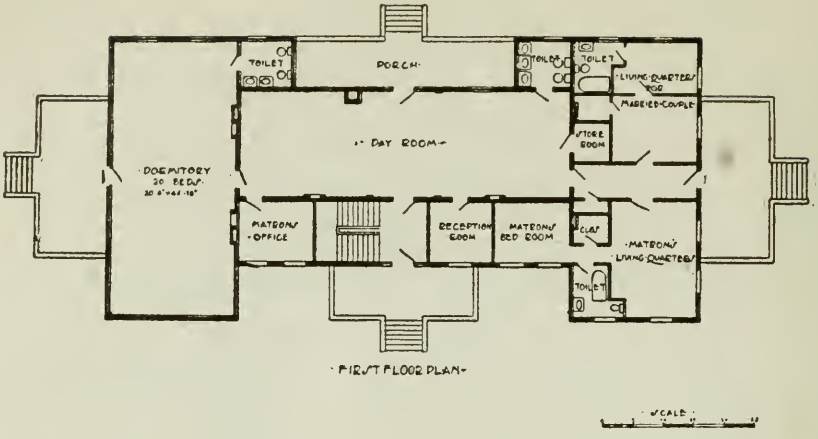
SECOND FLOOR PLAN

MASS. SCHOOL FOR THE FEEBLE-MINDED

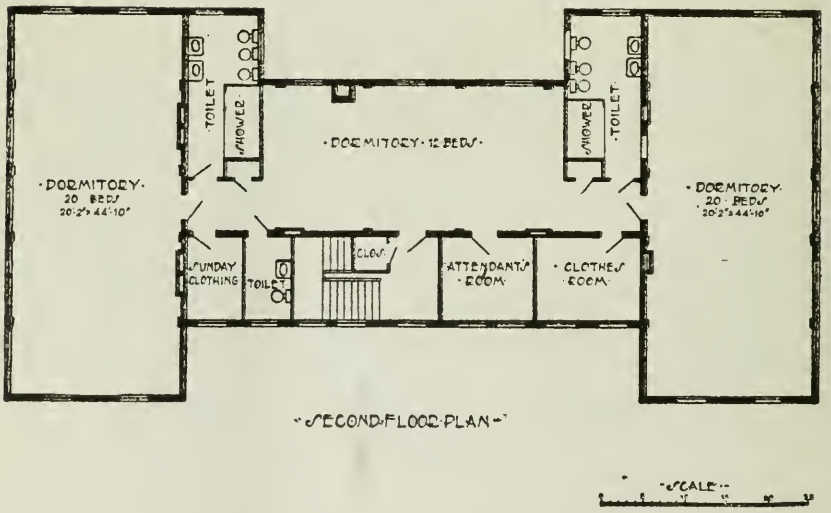


BASEMENT FLOOR PLAN

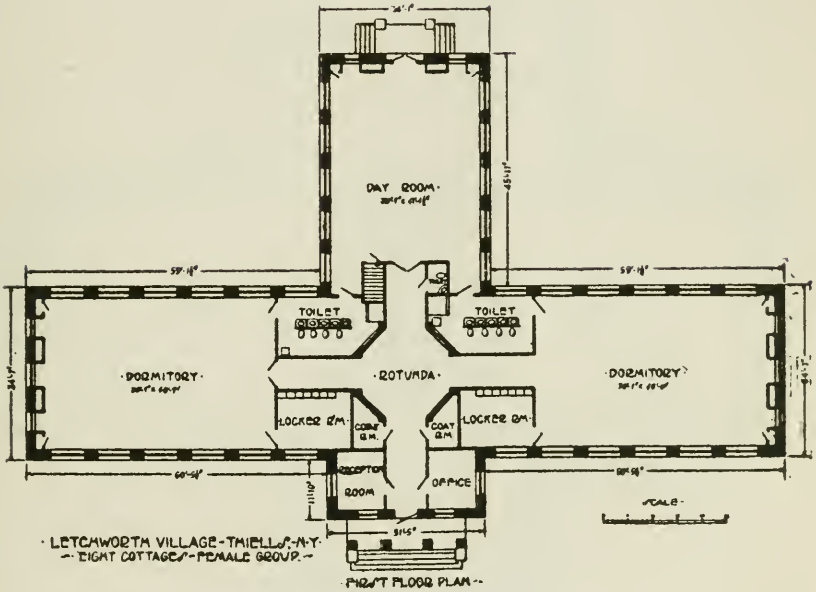
MICHIGAN HOME & TRAINING SCHOOL - LAPEER, MICH.
FARM COTTAGE



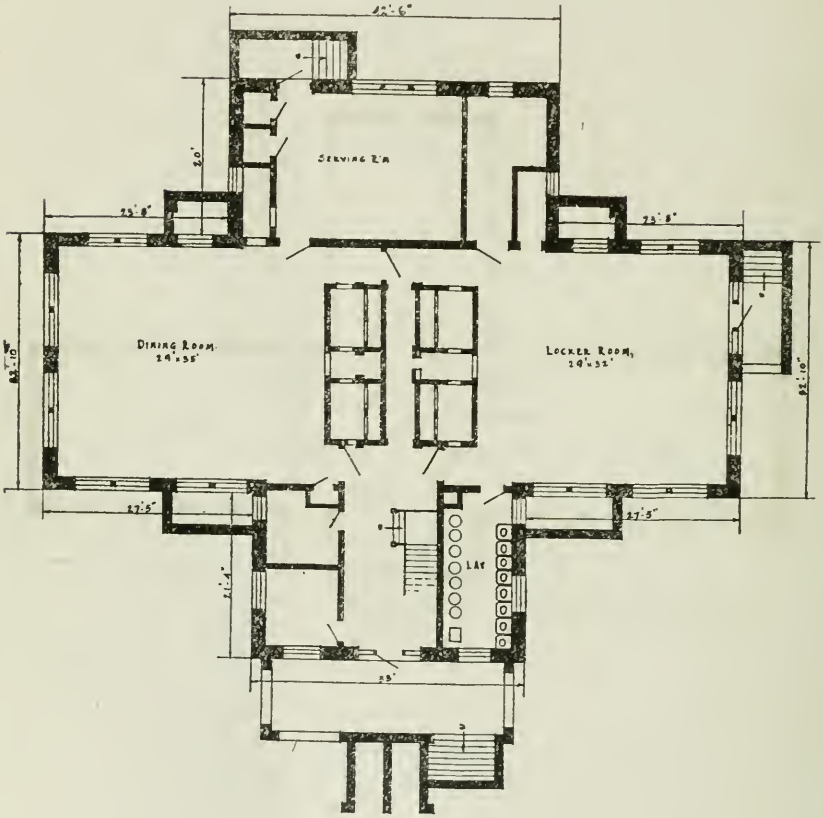
MICHIGAN HOME & TRAINING SCHOOL - LAPEER MICH.
FARM COTTAGE



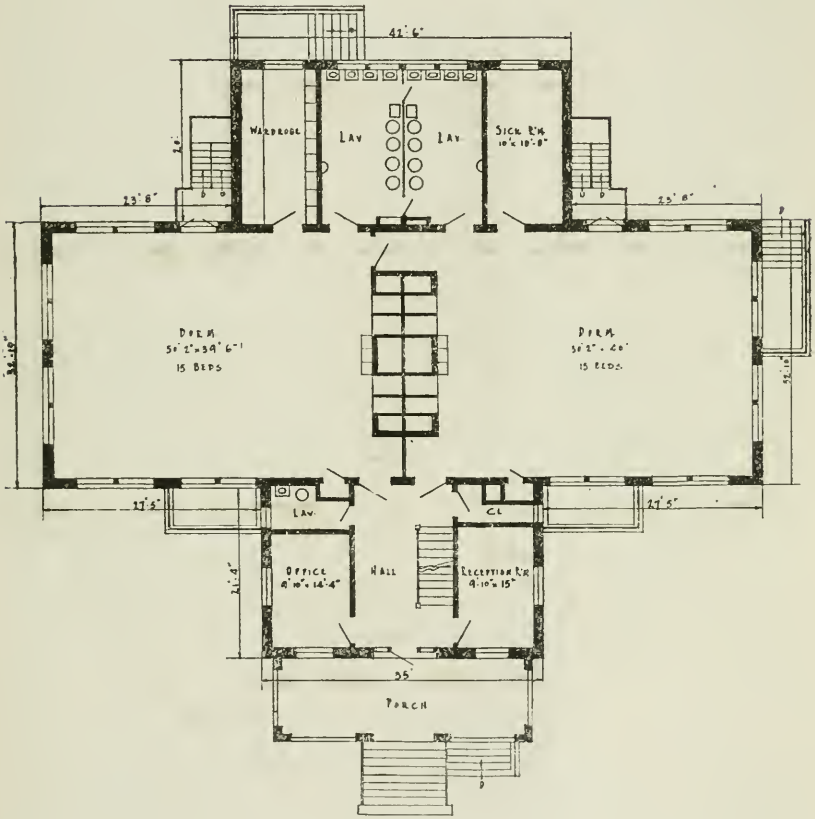
MICHIGAN HOME & TRAINING SCHOOL - LAPEER MICH.
FARM COTTAGE


DAY ROOM
TOILET
TOILET
DORMITORY
ROTUNDA
DORMITORY
LOCKER RM.
CLOTHING RM.
COAT RM.
LOCKER RM.
RECEPTION ROOM
OFFICE
SCALE
LETCHWORTH VILLAGE - THIELLS, N.Y.
- EIGHT COTTAGES - FEMALE GROUP. -
FIRST FLOOR PLAN

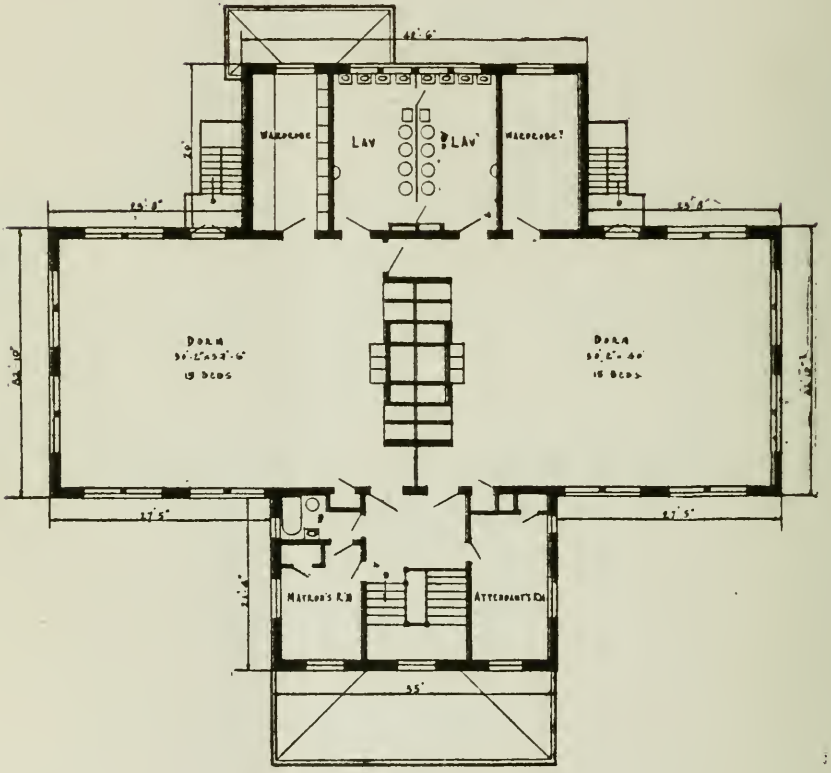
WRENTHAM STATE SCHOOL, WRENTHAM, MASS.
DORMITORY G.
BASEMENT FLOOR PLAN.

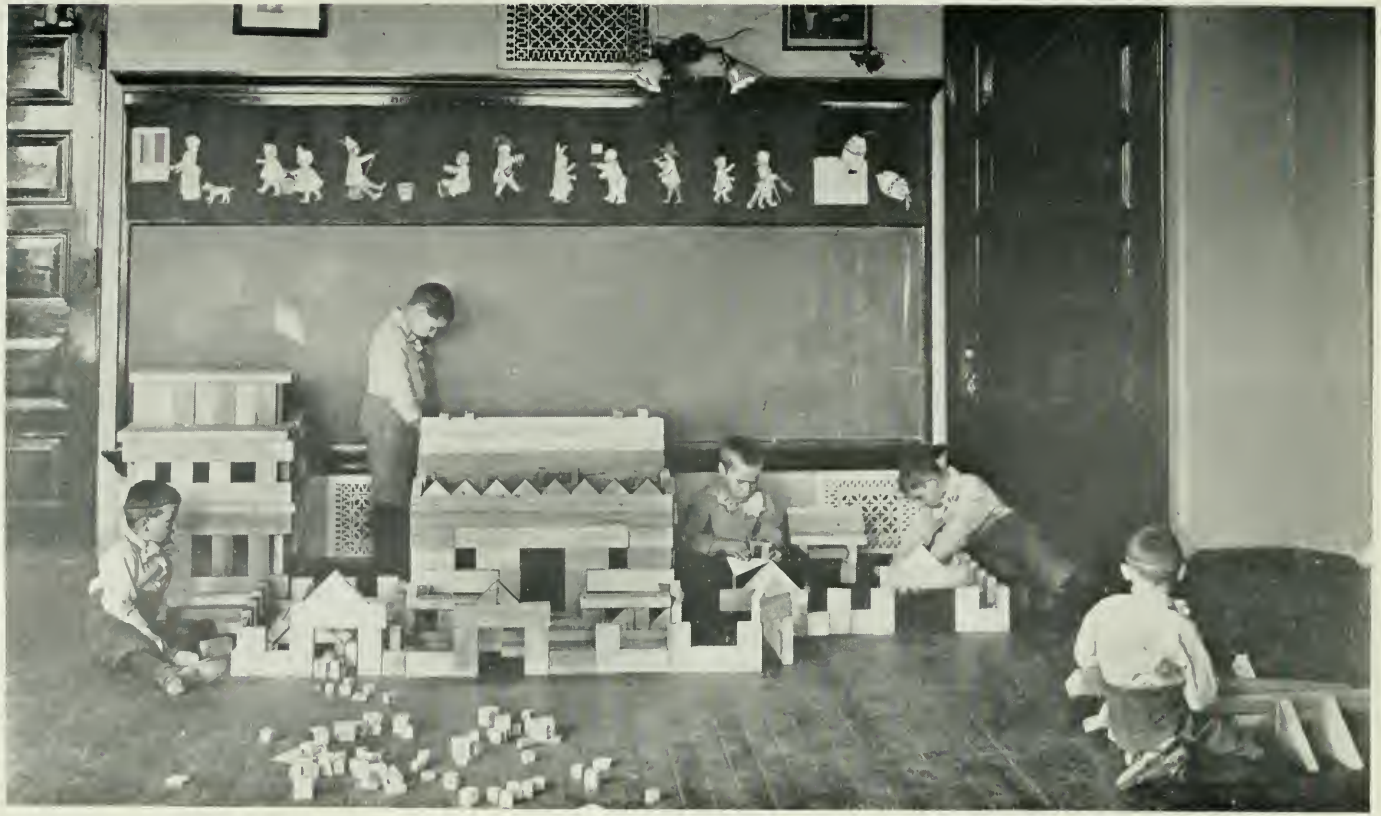


WRENTHAM, STATE SCHOOL, WRENTHAM, MASS.
DORMITORY G
FIRST FLOOR PLAN.



WRENTHAM STATE SCHOOL, WRENTHAM, MASS.
DORMITORY G.
SECOND FLOOR PLAN





The kindergarten

Manual-training class

Varied occupational training

Varied occupational training

Printing

Broom making

Making and repairing shoes

The tailor shop

Girls' sewing and dressmaking class

Making clothes for the children

Class in domestic science

Lace making

Knitting

Basket making and chair caning

Physical training

Boys' basket-ball game

The orchestra

Boys' band

Stone taken out by the boys

Removing large boulders

Carting away smaller stones

Potato harvest on cleared land

Farm produce to be shipped to the parent institution

Repairing their own cottage at the colony

Brick making

The cottage plan permits of adequate classification and should be carefully developed with this in mind. The males should be separated from the females. The improvable and educable boys should be in a group by themselves, quite distinct from the adult males and the infirm.

Adult males should be located near large tracts of land available for farming purposes, in order properly to utilize their labor in farm, dairy, and garden operations.

The young and teachable girls should be separated from the women and the infirm females. The women should be located between the laundry and the group for infirm females, thus providing economical utilization of their services in these departments. They can also be profitably used in connection with gardening, chicken raising, fruit growing, canning, etc.

The higher-grade types should be cared for in small groups. The lower-grade type of imbeciles and idiotic patients can be cared for in much larger groups to advantage.

Administration

The administration of such an institution will depend upon its size and character. The most important question in this connection is the selection of a superintendent. He should essentially be a medical man with special training and experience with the feebleminded. He should be a man with executive ability, of good business judgment and keen human sympathy. There are those who argue that a layman is a better business man than a medical man, and consequently that a layman should be in charge of the institution, but it should be remembered that this is not purely a business proposition. The humanitarian aspect of the work cannot be ignored, and the medical side of the question particularly is so closely linked up with the business side that it is impossible to separate one from the other. Each day will see many problems arise that are neither solely business in nature nor solely medical, but both. It can be definitely stated that the layman, the purely business man, does not get the patient's point of view, while the medical man not only grasps fully the varied mental, physical, and social aspects of mental deficiency, but can appreciate the purely business side as well as the layman.

The superintendent should draw around him a very carefully chosen staff of physicians, teachers, matrons, and attendants. The success or failure of the institution may well depend upon the character of personnel chosen. Particular care should be devoted to the selection of matrons and attendants, who live with the children and on whose shoulders falls the daily burden of caring for them. Personality should rank high, and there should be an understanding insight into the problems of the feebleminded child.

Institutional Activities

Some of the children are as helpless as infants, incapable of standing alone, dressing, or feeding themselves. The chief indication with these lower-grade cases is to see that their wants are attended to and to make them comfortable and happy as long as they live; but even with these cases much improvement is possible in the way of teaching them to wait upon themselves, to dress and undress, to feed themselves, and to give attention to personal cleanliness and habits of order and obedience. In this way large groups, even of low-grade cases, may be made less troublesome, and the burden and expense of their care considerably lessened.

Manual training and such methods are more especially adapted to the development of feebleminded children than the ordinary school-grade and academic work. The methods of physiological training of the senses and of exercising and developing the powers of attention, perception, and judgment by teaching the qualities and properties of concrete objects instead of expecting the child to absorb ready-made knowledge from books—of progressively training the eye, the hand, and the ear—these are the methods best suited to developing the feeble mental powers of the defective. Such regular grade work as is given is done along more intensive lines, and in much smaller groups, than in the public schools—about fifteen children in a class.

A most prominent feature of the educational training in our best institutions to-day is the attention paid to industrial occupations. Fernald says, "In this education by doing, we not only have a very valuable means of exercising and de-

veloping the dormant faculties and defective bodies of our pupils, but at the same time we are training them to become useful men and women." Carpentry, painting, printing, brick making, shoemaking, tailoring, dressmaking, broom and mattress making, stock raising, dairying, farming, domestic work, and other industries are now successfully carried on by pupils in schools for the feebleminded in connection with the strictly mental training. They not only prove profitable in the way of financial return to the institution, but form a splendid outlet for the energies of the over-active and disciplinary cases, besides offering an occupational basis for those who are later to be supervised under parole.

The gymnasium is a very important phase of institutional life. It is the center for varied physical training, folk and classic dancing, basket-ball games, orchestra and band music, etc.

An essential part of the institution is the farm and colony. A large proportion of the feebleminded can be usefully and profitably employed if intelligently directed. They can clear waste land, grub bushes, remove stones, build fences, make roads, drive teams of oxen or horses, milk cows, feed pigs, take care of chickens, cultivate land, and gather crops. They can excavate for buildings, haul stones, make brick and cement blocks, and do the necessary painting to keep the buildings neat and attractive. In states where the colony plan has been utilized and intelligently directed, as it has in the Templeton Colony in Massachusetts, large crops have been yearly grown and unusual success has been obtained from this method of treatment. The entire cost of Templeton Colony, which comprises about 1,814 acres of land, including the land, the central farmhouses, and the repairs needed to fit the old dwellings for use, amounted to only $378.00 per capita for the 300 inmates for whom provision was made. This cost is probably less than any similar provision for the feebleminded in this or any other country. Many of the children who at the training school found the necessary restraint irksome are free at the colony to come and go. The destructive tendencies often marked in the schoolroom find their outlet here. Instead of breaking windows, destroying furniture, or setting fire to buildings, as these children so often do when confined in penal

institutions, they cut down bushes, pull up stumps, burn brush heaps, and make waste land available for farming, thus increasing its value and decreasing the cost of maintaining themselves as the wards of the state.

Another and very far-reaching method for handling the feebleminded on a colony basis is that which is being so successfully demonstrated by Dr. Bernstein at Rome, New York. He is placing groups of high-grade girls under the careful supervision of well-trained and trusted matrons at work in domestic and other service in certain localities of the state. A house is rented for these girls to which they return at night, and all of the comforts and pleasures, as well as the restraints, of regular home life are thrown around them.

Each and every child, upon being received in the institution, should be given a careful and searching mental and physical examination. The results of these examinations should be made the basis for permanent records. At stated intervals reëxaminations should be given. The medical treatment and educational training of the children will naturally to a great extent be guided by the information furnished. The pathological, the psychiatric, the psychological, the educational, and the social work of the institution, properly coördinated by the superintendent, should each constitute a part of a comprehensive scheme for the study, treatment, and training of the individual child, and should not in any sense constitute independent units, each revolving on its own axis, separate and distinct from the others. Out-patient clinics should be conducted by the staff of the institution at various cities and towns throughout the state, serving the general community, the schools, the courts, and various social agencies. It should be possible to establish contact between the institution and the university and normal school for the purpose of training future physicians and teachers in the field of mental defect.

Parole

It has been fairly well determined that the average adult male defective who does not possess serious personality difficulties, who has been properly trained in habits of obedience and industry, and who is adequately protected from tempta-

tions and evil associates, can be safely paroled into the community. Dr. Fernald reports that a careful study of the discharges from Waverley for twenty-five years showed that a very small proportion of the discharged male morons had committed crimes, had married or become parents, had failed to support themselves, or had been bad citizens. We know enough about mental defect to-day to be able to state that there are good and bad mental defectives, that some feebleminded individuals possess traits of character and handicaps of personality that make it absolutely impossible to handle them out in the community, while other defectives, because of a desirable personality make-up, possess a very definite community value, are fairly efficient industrially and adaptable socially, and can be properly supervised outside the institution. The relation that a properly worked-out parole system will bear to a broad and comprehensive state policy for handling mental defectives is quite obvious.

The business man and the taxpayer will doubtless, for some time to come, be unwilling to segregate all defectives purely on the theory that some of them may become delinquent and dependent, so that complete institutional provision for all defectives can hardly be expected. If, however, a period of careful training suited to their particular needs is given to every feebleminded child, and those children who are able to profit by such training and who possess community value are given careful supervision throughout their lives, while those whose tendencies are such as to make them undesirable members of the community are permanently segregated in the state institution, then a very satisfactory solution of the burden of feeblemindedness will have been reached.

Summary

The problem presented is to plan an institution that will remove a large number of feebleminded from the community; that will satisfy parents that their children will be humanely treated; insure the happiness and comfort of the children; educate or train each one according to his abilities; provide such facilities as will utilize the labor of the trained inmates to reduce the cost of their support; secure and retain high-

grade employees; build to satisfy all requirements; meet the topographical conditions of the site; separate the inmates in groups for proper classification; plan the buildings for simplicity and economy of administration, with a minimum outlay for repairs and upkeep; organize and develop scientific research into the causes underlying mental defect, its extent, and its menace, and the best methods for meeting and solving the problem that it presents; parole and supervise out in the community those children who have profited well by institutional training and are able to adapt themselves to normal life; furnish clinical facilities for diagnosing mental defect in the general community, in the public schools, and in the courts; offer opportunity for the training of teachers and medical men in the diagnosis, treatment, and training of mental defectives; and, finally, do all this at a cost in accordance with modern business standards.

THE STATE HOSPITAL AND THE PAROLE SYSTEM*

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IT is of interest in the consideration of this subject to note that the first meeting of the National Conference of Charities and Correction, in 1874, was devoted chiefly to the subject of the duty of the states to their insane poor. Those who were present will recall that the first address was made by a physician.

Times have changed since that day and there has been marked progress in the care of the insane who are no longer called poor. To-day many of the states are not only affording the highest type of medical treatment and skilled nursing, but, as Dr. Adolf Meyer phrased it, "are reaching out into the community and becoming responsible for the mental health of the district served by the individual hospital." I believe the state hospitals, through their psychiatrically trained medical officers, are coming to appreciate more and more the great importance and value of medical and social work with mental cases outside the walls of the institution.

The parole system is one of the principal phases of the outpatient work of state hospitals, and it is dependent for its success quite largely upon the other chief factors—namely, the hospital social worker and the mental clinics or dispensaries operated by the physicians of the hospital staffs.

The parole was a valuable method of returning a patient to his home environment even before social workers had been employed or mental clinics established. It had a certain restraining influence on the patient and was something of a comfort to the relatives, who knew that the patient, while on parole, could be returned to the hospital without delay and without the expense, formality, and often notoriety of another commitment. Probably it was often used as a big stick

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over the patient by reminding him that he was still on parole and would have to go back to what was then known as the "lunatic asylum," if he were not careful to act as the other members of the family thought he ought to act, though they may have been no saner than himself.

The coming of the hospital social worker and the establishment of mental clinics out in the community have increased both the scope and the efficiency of the parole system.

The maximum length of the parole allowed by statute varies from three months in some states to two years in Wisconsin. In Arkansas, patients may be paroled for one year, and this may be extended to another year if application be made for such extension. This wide variation makes it impossible to draw exact comparisons with respect to the operation of the parole system throughout the country.

The increase in the number of patients on parole from the thirteen New York state hospitals coincident with the establishment of social service in the majority of these institutions is very striking. At the end of the fiscal year September 30, 1913, there was a total of 861 patients on parole. The following year saw each hospital equipped with a social worker. The number on parole went to 1,300. In 1917, it had increased to 1,559, and it has steadily grown until on March 1, 1920, it was 2,283. It is safe to say that at least a thousand patients in New York are enjoying a parole in their homes who would still be in the state hospitals were it not for the social-service supervision given them. This means a financial saving to the state in maintenance alone of approximately $1,000 per day. The lengthening, in 1917, of the statutory maximum parole limit from six months to one year should be mentioned in this connection, but since it is only certain types of patients with certain environmental difficulties that call for a full year's parole, this increase in the possible period does not begin to account for the growth in the number out on parole.

The New York legislature has just made provision for additional social workers to the extent that each state hospital will have at least one worker for each hundred patients on parole. Massachusetts has a state director of social service and a corps of nineteen social workers, the largest number employed by any state to-day. Dr. George M. Kline, Com-

missioner of Mental Diseases in Massachusetts, recently wrote, "It would seem that the parole system was adequate, although its scope could be enlarged through the employment of additional trained workers." Dr. H. Douglas Singer, Alienist of the Department of Public Welfare, Illinois, writes: "The most important measure for increasing the number on parole is provision of an efficient social-service department, with facilities for placing and supervision of patients. These measures are only just being instituted in this state and at the present time we have four social workers at the Chicago State Hospital, one at the Jacksonville State Hospital, and one at Elgin."

The practical value of social service during both the hospital and the parole period is well expressed by Dr. George H. Kirby, Director of the New York Psychiatric Institute: "The length of the hospital treatment will often depend directly upon what the social worker is able to do towards changing unfavorable home conditions, smoothing out causes for friction, and educating the family regarding the management of the patient on his or her return home. * * * The social worker should attend staff conferences and get acquainted with each new case as soon as possible.

"As each case is first presented and discussed, the physician should state whether or not the case offers a social-service problem at that time and indicate the ways in which the worker can be helpful in the diagnosis and treatment.

"Later on, when parole of the case is granted, the physician should be responsible for a final formulation of the social-service problem then offered, with special reference to the modifiable factors concerned in the mental breakdown."

Mental clinics distributed throughout the hospital districts are invaluable in the operation of an extensive parole system. Massachusetts has forty of them, New York over thirty, and other states are falling into line. Many parole cases find it very difficult to return to the hospital at regular intervals for medical counsel and treatment, but are very willing to attend a nearby clinic where they are met by the hospital physicians and the social worker. Furthermore, some of them have a hesitancy about returning to the state hospital that they do not have when it comes to attending a mental-hygiene clinic,

especially if it is held at a general hospital, a health center, or in connection with other clinics. I should call attention to the fact that in New York State these clinics are being enlarged in scope to provide for the examination and treatment of mentally defective cases. This additional work is being done very largely under the direction of the State Commission for Mental Defectives.

The fundamental necessity of having the active interest and constant support of the physicians of the staff for all phases of successful out-patient work is so evident that it hardly needs emphasizing. Unless the physician in charge of the clinical work of the institution inspires the physicians under him to use every possible means to promote the parole of patients, any parole system will soon be more system than parole.

There are several constructive suggestions that might be offered in connection with the progressive development of the parole and mental-hygiene activities of a state hospital. All who are closely connected with the problems pertaining to the mentally sick seem to be unanimous in recommending the establishment of more mental clinics and the securing of many more social workers. Six patients at home on parole represent a saving to the state equivalent to the salary of one social worker. Since the additional number of patients on parole in New York as a direct consequence of the social service given averages about eighty patients per worker, the state must be making about 1,300 per cent on this investment.

A recommendation made by Dr. Thomas W. Salmon, Medical Director of the National Committee for Mental Hygiene, is a "systematic and continuous survey of the institutional population, together with some plan of intra-hospital transfer which will tend to disclose cases likely to be benefited by a new environment." He also suggested the need of "speeding up and intensifying public education regarding mental diseases. In many cases a parole results in failure because of an improper attitude on the part of the people in the patient's family or neighborhood. With a proper attitude on the part of the people interested, such patients would get along with entire success. The unfortunate attitude usually taken depends, of course, upon the medieval ideas of

mental diseases which still so largely prevail; * * * of course no agency for public education is quite so good as the social worker herself." Dr. Garvin, Superintendent of the Kings Park State Hospital, New York, suggests along the same line that "the clinical director should, every four months at least, make a survey of the entire institution with the coöperation of the ward physicians, in order to examine patients who may be parole possibilities. This constant combing of the institutions for parole patients will certainly prove of value in increasing the number on parole."

Another state-hospital superintendent has outlined such a practical method of encouraging employees to train patients up to a parole that I quote at some length:

"The roots of this system reach back into the whole management of the hospital in its relation to the patients. The doctors on the staff and the board of managers should be imbued with the idea that about the worst place for a patient or a lethargic employee is the ward of a state hospital. All must be taught that the more time spent 'off the ward' each day by every patient, the better for the institution and the patient.

"*With this point in view,* no employee is expected to go anywhere or do anything without taking one or more patients along; no matter how small the job—one, two, three, or more patients have the right to go along.

"Patients should be sent at first on little errands in the ward, and then off the ward under the eye of the attendant, and then for short distances out from under the eye of the attendant; then for longer trips—to be followed by more and more liberty. During this process lapses by the patient should be readily overlooked and the 'try and try again' motto must prevail.

"*With this point in view,* the patient should then be allowed to earn a little money by doing chores or light jobs for the neighbors, and when things go smoothly, should be allowed to keep the money for spending. It is easy to see that after the patient has developed to this point, he or she is on the high road to being self-supporting, but it is just at this point that the great obstacles begin to show up. Thus far I have been able to make quite a feature of the plan without getting into

serious trouble with the neighborhood or with the labor organizations.

"Furthermore, the employees who are promoted from the ward service to positions in the industrial departments should be trained in mental nursing (occupational therapy). The mental nurse in the carpenter shop, bakery, kitchen, store, laundry, etc., proves to be valuable in developing the patients toward parole and subsequent self-support. This is another hard nut for the 'powers above' to crack, but if the industries of the hospital are to be used in occupational therapy, or as a means of bringing patients nearer sanity, this nut contains the meat from which the tree will grow to enormous proportions. Personally, I never could see how it should be hard for a state-hospital man to grasp this thought and put it into successful operation, unless it was that there was more solicitude for getting work done cheaply and well than for returning the patient to his home."

Occupational therapy will prove of great value in raising the mental level of the patient by training him in habits of industry and by developing his ability to meet the problems of everyday life. It has been suggested by Miss Macdonald, of the National Committee for Mental Hygiene, that an occupational-therapy shop or center for paroled cases would undoubtedly provide a means of increasing the patient's adaptability to community life, would stimulate him to help himself, and, as a halfway house, would be of great help during the first trying days of making adjustment again to life out in the community.

The development of a scheme of coöperation between the hospital social worker and the public-health nurses, visiting nurses, and social agencies in the district would be of very great benefit to the out-patient work of the state hospital. Local volunteer mental-hygiene societies could render valuable aid, especially in the rural sections not visited frequently by the hospital worker.

In summarizing, I would say that the parole system is an indispensable factor in the successful operation of a modern state hospital. Its highest efficiency and greatest value to the patients and the community can be attained and maintained

only by constant vigilance on the part of the medical staff, by the establishment of more mental-hygiene clinics, by the employment of a much larger corps of psychiatric social workers, by thoroughly organized occupational-therapy and rehabilitation activities, and by developing further coöperation with public-health nurses and various social agencies and mental-hygiene societies in the territory served by the hospital.

INFLUENCE OF WAR UPON CONCEPTS OF MENTAL DISEASES AND NEUROSES*

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A SCIENTIFIC friend of mine has suggested that in the next war—and he seems to be convinced that there will be a next war—an army of scientists will be mobilized at the first indication of hostilities. He foresees that such a scientific army will accompany the fighting contingents wherever they go, in order to take immediate advantage of the extraordinary opportunities for scientific exploration that a war in the modern sense of the word affords. His point—and therein is its novelty—lies in the fact that such a scientific army will have no direct military object, but will be organized to take advantage of the free exploitation of the treasures of civilization which a state of war spreads over the face of the earth. War in this sense becomes a kind of scientific emergency, and the free play of scientific minds across the field of this emergency should yield a rich harvest.

War Contributes to Science

That wars hitherto have not been rich in scientific conquests is explained by the fact that in no war has there been an organization planned to add to the sum of knowledge by utilizing the research opportunities unloosed by nations fighting for their existence. However fanciful this notion may be, it holds an element of truth and this truth is the propelling motive behind this meeting of the American Association for the Advancement of Science. In the war an initial organization of this kind was attempted, chiefly in those branches of science the application of which had a distinct military or combative purpose. Physics, chemistry, geology, meteorology, and

* Read before the American Association for the Advancement of Science, Section on Physiology and Experimental Medicine, St. Louis, Mo., January 2, 1920. Reprinted with permission from *The Modern Hospital.*

medicine all have a miltiary significance. In the final period and up to the armistice the organization of such departments had reached a definite degree of excellence.

In war there is a curious change in the habits and thought of a people, chiefly due to the fact that there is a state of emergency, upon the proper solution of which the safety and existence of that people may well depend. It is here that the trained mind of the scientist comes face to face with his opportunity, and it is to his everlasting credit that in this crisis he has not been found wanting. The war against ignorance is transferred from the laboratory and the classroom into the actual area of conflict, and the same method which is effectual in one place is effectual in the other. Search for truth is concerned but little with motives except those inherent in truth itself; and response of scientific spirit, activated by the call of dire necessity, is as true to the underlying laws of scientific reasoning in a hut near the front lines as in a well-lighted and warmed laboratory on the picturesque campus of a university.

You can visualize, then, a body of scientists as an integral part of the armed forces in the next war, prepared to gather from the destructive agencies that will then be let loose such data of new knowledge as may add to the hard-won assets of man's urge towards a completer understanding of the universe. The tendency to see in destructive happenings elements of gain is but a reflection of the spirit of rationalization. It is man's excuse for his intemperate and illogical ways of doing things. It lies behind the question so often asked of those returning from overseas: "What has been the gain to you or to your branch of knowledge out of the four years or more of fighting?" The purpose of this paper is to put that rationalization in concrete form by telling in a brief way what one department of medicine has gained and to point out how that gain—or illumination, as I choose to call it—has resulted from the application of pre-war experiment often of a highly theoretical nature, developed in many laboratories and from the accumulated experiences of many clinical students.

The problem concerns itself with the reactions of the nervous system of a soldier in the face of the destructive agencies

of modern warfare. This nervous system had to face the shattering force of high explosives, the new horrors of aërial bombs and lethal gasses, machine gunning, unutterable weariness, and all the other agencies of destruction that the scientific energies of the human mind, bent on extermination, could devise. Let us assume for a minute that the nervous system of the soldier was made the object of a series of laboratory experiments in which every sort of disintegrating force was applied to it in order to see, observe, and measure the resulting phenomena. A wealth of information of the greatest value would assuredly come out of controlled and carefully planned tests of this kind. The war was such a laboratory on a colossal scale and with an enormous number of experiments, with the difference, however, that in the war the experiments were neither planned nor controlled; there was little laboratory equipment and no important body of trained observers or assistants. Such as they were, they had mostly other things to do, chiefly the task of getting the same laboratory subjects back to the fighting lines as quickly as possible, so that they could be experimented on again.

Value of Uncontrolled Experiments

As a result of these uncontrolled experiments what new thing came out and how much was added to the total of our knowledge of the nervous system as a whole? In other words, because of the war experience do we know more about the nervous system? If we do, how is it possible to make use of this gain towards solving the problems of the civilian conflicts which this same nervous system must meet? It can be conservatively stated that at least 20 per cent of the total casualties, exclusive of disease and infections, was concerned either directly or indirectly with the nervous system — that is, wounds of the peripheral nerves, spinal cord, brain, and that shock to the nervous system unaccompanied by demonstrable changes in the anatomical integrity of the nervous system called "shell shock" or war neurosis. In the American army alone at least 20,000 individuals would fall in these categories. This, then, constitutes the material for investigation, if a body of neurologists and psychiatrists had been sent over for

that purpose. Is it any wonder that this friend of mine should have been impressed by the scientific opportunity offered by a great war? Is it not a matter of importance that the next war should find scientific preparedness a little more forehanded?

The material for study was much more extensive than this, for it is to be remembered that the medical examination of hundreds of thousands of recruits in the United States has brought out facts of the greatest importance. There was given an opportunity to study the nervous system of four or five million of easily controlled youthful male citizens—prospective soldiers. After the obviously unfit were excluded, the normal residue was transferred to training camps where it became, or might have become, an object of neurological and psychiatric study from the point of view of the reaction to military training and military life. Then, sifted again, with the rejection of the unfit, these soldiers were sent overseas, further trained on foreign soil, and directly prepared for active participation in the combat. Here again the unfit were rejected and those remaining, presumably sound and fit to be combatants, were sent to the forward areas and lived thereafter under conditions of actual fighting. The nervous system of that army was then subjected to the physiological test of meeting series of destructive influences, and the results—wounded or sick soldiers—were gathered together in special or base hospitals for treatment and such study as the exigencies of the situation afforded. After the armistice the uncured residue was sent home to become the charge of the Public Health Service, where further study can be carried out.

This merely sketches out the material that a war furnishes for study, a war which engages the whole man power of a nation and in which the total strength of a people is called into activity. In spite of the fact that this war could not altogether be looked at as a series of countless physiological experiments, there came out of it much to stir the imagination and awaken the enthusiasm of the neuropsychiatrist. It may be regarded chiefly as a kind of illumination, a sort of light thrown unexpectedly into dark places, giving often enough merely a fleeting glimpse of what the problem really is and how a solution may come about. A glimpse around the corner may express this more fully. A science is enriched not by

facts alone. Very often a shifting point of view, a new insight, a novel background, are the permanent gains and lead the way to more constructive thought and experimentation.

The war has enriched neurology and psychiatry by the stimulus it has given to numerous workers in this field, by the opening up of new pathways, and in encouraging students in its ultimate possibilities.

The nervous system is a very complicated structure out of which develop and upon which are based groups of complex mechanisms. These have to do with the physiology of the nervous system—chiefly with the problems of the integration of nervous impulses to and from the various centers of coördination; also, with the development of functions of consciousness and personality. Each of all of these may show reactions of an abnormal kind as a result of the material and emotional shocks of warfare.

If, for example, a machine-gun bullet severs completely the ulnar nerve, the resulting paralysis of the muscles supplied by that nerve and the accompanying sensory disturbance, from the point of view of a laboratory experiment, present a complete conduction break in that nerve. The phenomena that follow are of two kinds. One groups itself about the anatomical changes produced in the distal and proximal part of the nerve deprived of its nutritional cells in the spinal cord, the degenerative action at the point of severance, and the tissue changes resulting in the section of normal nerve fibers and its replacement by fat and other abnormal tissues. If the severed nerve is reunited by suture or if there is a bridging of the space of separation, there develops a reaction of functional readjustment, an effort at regeneration which sets forth the physiological problem and frames the anatomical picture. The other group of phenomena concerns the individual deprived of the use of his ulnar nerve by the failure to unite. If the period of regeneration is unduly prolonged, he takes note of the experiences which accompanied that injury and gives way to depression and discouragement, and, falling a victim to the organization of such a state, he develops a change of personality which may finally completely overshadow the ulnar injury. Follow that soldier to his home after discharge from the army and observe that he

comes back as a handicapped man to whom the necessary adjustment to a different kind of employment comes hard or is impossible. Think, then, of the long contemplation of his injury, the notion that the government should be at least materially concerned with his plight, his disappointment at the reception which a wounded defender of his country receives, the economic and social responsibility piling up on him, and other things of a like nature, and you can sense something of the consequences of that simple military experiment performed in the laboratory of the Argonne Forest. This sketches in a crude fashion a phase of the problem which neurology has had to face in this war, and this is a simple example.

Here is another: A soldier receives a fragment of a high explosive shell in his cortex after it has fractured a part of his skull. With return of consciousness and after his wound has been healed, with the fragment removed, he finds that he can move his right side only with great difficulty and that he is unable to pronounce the word which is in his mind, nor can he express an idea clothed in the words which seem to him present in his consciousness. He is paralyzed and aphasic. His recovery is slow. He returns home able to walk with a limp, but unable to speak or write with his former facility. Some time later he becomes the subject of a convulsion and there develops slowly, but progressively, a condition of dementia, with such a change in his personal make-up that he must finally be removed from the social niche which he formerly occupied, and from his normal social environment.

Development of Defense Amnesia

The third example is of a different kind, and this experiment was performed with one or another of its countless variations some fifteen thousand times, at least, in the American Expeditionary Forces, some eight hundred thousand times in the French army, and more than that in the British forces. A soldier, after some fatiguing experience and possibly a period of sleeplessness, is subjected to concussion by the explosion of a shell which, falling in his neighborhood, renders him unconscious although no fragment touches

his body. He is tossed in the air, and his last remaining gesture, before he completely passes out, is a gesture of defense against the onward rush of the air compressed about him. He partially regains consciousness in some hospital far removed from the scene of this experience, and finds, much to his astonishment, that his arms are in a state of constant movement, carrying out the defensive gestures with which he ended his last conscious moment. On examination by his medical officer it is found that he cannot feel the prick of a pin on one side of his body and that he is unaware of the position, on one side, of the smaller joints as they are moved in testing for his sense of position. He has at first only a vague idea of what has happened to him, but with returning consciousness, more of the picture and its attending horrors rise up in his mind. He recalls with a remarkable degree of vividness that his chum who was next to him had disappeared in a blinding flash of some explosion and that portions of the disintegrating body had spattered over him. This memory and the attendant circumstances fill him with such intense horror and arouse in him such an intense degree of emotional reaction that suddenly the whole incident, together with many that preceded and followed it, are blotted out of his mind. He develops a defense amnesia, and a break in the continuity of his memory stream results. This defect in consciousness acts like a foreign body, giving to him the sensation of something strange and queer, something that dissociates his personality, in that particular segment, from reality. In this state he lies in his hospital bed, the prey to all the agonizing emotions resulting not only from a serious shock to the nervous system as such, but those due to a sense of mystery and misunderstanding.

This exemplifies a picture of "shell shock" or war neurosis, and not a very serious case as it happens to be—such a one as has been cured by the hundreds in all the armies. It is necessary to note that in the last example of injury to the nervous system nothing tangible has been produced in the way of a destructive process in the tissues of the brain, but there has been brought into action a curious and interesting reaction of the nervous system—the primitive reaction of defense, resting upon the instinct of self-preservation and activated by the protective emotion of fear. For the time being,

at any rate, the individual so shocked is in no condition to repeat the experience that has brought him to this condition, and this protective neurosis will exist until his organism is again fit to take up military activities. The fixation of these symptoms and their elaboration into a more permanent system of defense can be prevented by skillful treatment.

The Rôle of Neurology and Psychiatry in Medicine

It is something of a task to put down in a definite way just what the war has given to neurology and psychiatry and to point out in a positive fashion just what and where the gain has been. Even a record of new facts or new ideas will not convey the essential thought that, through the exigencies of war, neurology and psychiatry have come to something of their proper place in the domain of medicine. There has arisen the idea that in civil life, as well, there occur conflicts from which the nervous system comes out shocked and traumatized in the same essential manner that the nervous system of the soldier suffered in the more incisive and immensely more shattering conflicts over there. The social and economic stresses with which our world is filled, plus the incidence of various diseases that seem to be the necessary accompaniment of our civilization, produce a similar degree of receptivity to shocks of all kinds that the more resistant nervous system of the soldier, in the face of the more acute and more generally physical shocks of the battle area, had to endure.

The current of thought that runs in the usual post-war discussion of the profit and loss that has arisen out of the war centers about the question as to methods by which the benefit of this experience may be translated into civilian life. If the war has granted a fresh insight into the perplexing problems of the nervous system and into the various phases of the functions of consciousness, what opportunity will there be to utilize these gains when the same problems are presented in the reactions of the nervous system to the conflicts and stresses arising out of our post-war civilization? It appears that this sort of forehandedness has been more usual and prevalent in the minds of the medical profession as a whole, and particularly the neurologists and psychiatrists, than has been the case in any war that we have any knowledge of. The

literature of the present moment, so far as it is concerned with the medical problems of the war, is permeated with the thought of this effort to translate the experiences gained in the area of fighting into the conditions that are present in the everyday life of the average community. In an attempt to analyze the applications of knowledge to war conditions and to establish some kind of measurement of what was accomplished, this trend must be taken into account. If no post-war use can be discovered for any measure that was found effective in the zone of fighting, it is reasonable to conclude that its efficacy was transient and the gain illusive. Such a measure would find its place in a war museum, with the "tin hat" and the gas mask.

In the domain of the actual physiology of the nervous system and the anatomical phase of this question, little can yet be said as to a definite increase in our knowledge. No new facts of great consequence came out of the many thousand cases of peripheral nerve wound, and no new physiological principle and no new note on the question of regeneration. There was some improvement in the technical handling of nerve wounds, and some more definite conceptions in respect to the manipulative treatment following surgical procedures. These touch more closely upon the questions of neuro-surgery, with which this paper has little concern.

Sensory Symptoms Following Severance

One phase of this topic deserves to be mentioned, however, as it points more readily to the type of illumination already mentioned. As these hundreds of cases of peripheral injuries came to be examined there was seen increasing evidence that the sensory symptoms following the severance and those that developed during the various stages of healing became a matter of physiological inquiry. The curious phenomena of the sensory overlap and the diversity in the sensory return lead back to a series of pre-war investigations associated with the names of a group of English neurologists and physiologists. The war can be said to have directed attention to the practical utility of this work, and to have made for a great increase in the care with which the resulting symptoms were followed. Much of this work is still uncompleted, and in the study of

the residue of such cases still under medical supervision in America the physiological questions that cluster about a regenerating nerve may reach some measure of solution. The war has furnished a great many instances of this kind, and it can be expected that for many years cases will be available for the intensive study that is required. In a similar fashion, the wounds of the spinal cord, of which there were many instances, furnish physiological opportunities. The functions of the spinal cord, especially its tendency to automaticity according to its primitive physiological and segmental structure, came in for much intensive study, and the Sherrington concepts received in the hands of at least one of his most distinguished students a full measure of testing.

The cerebral wounds and injuries resulting from shell and penetrating wounds of the skull gave a series of localizing experiments of extraordinary variety and complexity. Here, also, it is too soon to establish the permanency of the newly won facts. It will need all the experience that will be gained through the careful study of the reëducation of the functions that have been temporarily lost to determine if it is necessary to revise some of our previous points of view. There are now piling up in the notebooks of investigators the facts necessary for the final estimate of what utility all these cruel experiments may finally turn out to be. If, then, we review the whole aspect of the definite injuries of the nervous system, it is difficult to point out so far a series of definite gains to the various phases of the subject associated with the functions of the spinal cord or of the brain.

Utility of Pre-War Investigations

In the field of what has been called the functional diseases of the nervous system, among which war neurosis or "shell shock" takes its place, the war has been of great service in stimulating new lines of thought and giving unusual opportunity to test out and put into practical application the results of many years of pre-war study. It is upon this phase of neurology and psychiatry and its effect upon the demands that post-war conditions will undoubtedly furnish that the largest emphasis in a paper of this kind must be placed. The psychoneuroses, the civilian term given to that large group of ab-

normal nervous-system reactions which show themselves under the various clinical pictures called neurasthenia, hysteria, or psychasthenia, come to the front in the war as specific war-born conditions, called "shell shock," war neuroses, *nevrose de la guerre,* or *Kriegsneurosen.* In civilian experience these conditions are termed functional, because they were obviously not the result of organic changes in the nervous system, but were functional deviations resulting either from some shock experienced or a series of unusual happenings associated with powerful emotional content. These were often congenitally predetermined, suggesting that the nervous system in such individuals was incapable of meeting the demands made through environmental conflicts. Towards the interpretation of these conditions various theories and notions had grown up, and in a sense they had become crystallized almost into the rigidity of systems.

Response Is Essential Characteristic

The experiences of the war illuminated this subject from two important points of view: (1) it showed that any soldier under given circumstances would develop a neurosis and (2) it showed that the potential neurotic of civil life not only developed a war neurosis under less intense traumatic environment than the normal soldier, but also that such an individual was less capable of cure, and thus belonged to the uncured residue that filled up so largely this class. The gain resulting from this experience lies largely in the first category, reflecting as it does the proposition that in the civilian neurosis generally, and in the war neurosis particularly, we are dealing with fundamental and primitive responses of the nervous system. This response is to be considered as an essential biological characteristic of the normal nervous system. It stands ready to spring into activity when the organic safety of man is in danger. The traumata of civil life awaken this dormant activity mainly in those who possess a less stable mechanism of adjustment, while the more severe traumata of warfare arouse this protective mechanism in any one.

In order to connect up this reaction with the normal response, it must be founded upon some very general and primitive characteristic of living things, and particularly must

it be associated with some type of primitive response in man. This is to be found in primitive instincts. Two of these need only to be touched upon here—that of self-preservation and that of reproduction, or sex. The latter may be excluded in the present consideration as being included in the larger sense of the former term, or as showing itself in only very indirect reactions.

A normal nervous system under the stress and trauma of warfare, previously weakened by fatigue, hunger, and sleeplessness, in the presence of a sudden or unusual shock associated with extreme emotion, arouses the self-preservative instinct into dynamic activity, automatic and uncontrollable. Induced by the primary emotion of fear, this activity protects the individual through the elaboration and stereotyping of sets of functionally abnormal responses which, conforming to certain clinical manifestations, give the picture which is called "shell shock" or war neurosis. These protect the individual from reëxperiencing similar sets of traumata exactly as in the same way fatigue protects the individual from destroying his complete organism by fatal overuse.

Protective Quality of the Neuroses

This point of view is put into a dogmatic formula because it is only by so doing that we can suggest the illumination which it throws upon one of the least understood disease reactions of the nervous mechanism of mankind. The experience of the war based upon theoretical consideration, developed, but not capable of direct application until put to actual test, leads now to the opportunity to build up a psychological mechanism of the neuroses from the standpoint of primitive instincts. The tracing of this line of thought during four years of war is an interesting story, but lack of time prevents the statement here of more than the briefest outline. The start, perhaps, was from the earliest Freudian conception of the protective quality of the neurosis—its compromise aspect from the social point of view. The divorcing of this general reaction from the single factor of sex, a factor not seen in war, broke the thread of the Freudian process of thought and led to the seeking and finding of a more general principle. A

group of English neurologists and psychiatrists—Rivers, Rows, Hart, Meyers, MacDougall, Mott, and others—each from his special standpoint, added to the general trend of thinking on this subject until, at our own entrance into the war, the foundation had been pretty well laid. A good deal of the further crystallization of this thought was due to the fact that the American Expeditionary Forces had an adequate machinery for the studying of the war neuroses in the establishment of a special hospital for these conditions in the forward area. This was called Base Hospital 117. There was formulated, under conditions which in war times must be called ideal, a complete elaboration of the mechanism of the war neuroses. Here they were definitely established as clinical entities, typed and classified according to the notion just sketched. Here also were outlined certain ideas relative to the purpose and plan of the psychoses which in time may do for them what the study of the neuroses of the war type promises to do for the civilian reaction of a like character. The experience of the war showed that there were episodes in apparently normal soldiers which took on many of the characteristics which are common in the psychoses of civilian life. A study of these conditions, owing to their crudeness, their relative simplicity, and their acuteness of onset, permitted an insight into the intricate mechanisms of certain psychical states that may lead to pathways of inquiry of the most valuable kind.

A consideration of nervous and mental diseases, not merely as evidences of normal reactions themselves, but as reflections or as indications of the complexity of our social structures, leads directly to the larger view on this subject connoted in a phrase of to-day—mental hygiene. In the fighting area disease in general, and nervous disease especially, came to be viewed as an event of military importance. A deficit in man power meant defeat, and a sick soldier was the unit of this defeat. Particularly true was this in a case of a soldier who, instead of being the victim of a disease in the ordinary conception of the term, or wounded in an evident way, was taken out of his place in the line because his nervous system as a whole had failed to adjust itself to military conditions. Physically he was sound and often rugged. He was a soldier

in every way except that as a result of a shock his potential military capacity was incapable of translating itself into active fighting. The removal of such an unwounded soldier to a permanent place of safety was destructive to the morale of his comrades who were left at the front to endure the same kind of stress.

It follows that in any community under civilian conditions an individual who has failed to adjust himself to the demands of the civil conflict implied in the struggle for existence and to the economic social stresses, through the compromise of a neurosis, must be regarded as a citizen soldier for whose concern the community is responsible. Any one who falls a victim of a psychosis due to the same trend of causes takes his place in that community as a soldier who is prevented from carrying on his civic responsibility. For these maladjusted individuals the community must organize its best resources in order that return to duty may come about as easily and as promptly as possible.

Gains to Neurology and Psychiatry Summarized

The resulting gain to neurology and psychiatry which has come out of the war is to be measured by facts of a new sort, by conceptions in regard to mechanism and by ways of thinking about previously established problems rather than by new and fundamental medical discoveries.

(1) There have evolved certain definitely observed facts as a result of the wholesale experiments on the human nervous system. These facts have to do with the physiology of the peripheral nerves, the spinal cord, and the brain. When their analysis has been completed new light may be thrown upon these subjects.

(2) There has been established a working basis for the understanding of the neuroses based upon a psychology of instinct in which the primitive instinct of self-preservation and the emotion of fear have translated themselves into a protection for the individual under the guise of a disease picture.

(3) Certain groups of the psychoses are seen as episode reactions, closely related in origin and mechanism to the neuroses, but implying a more profound disturbance of con-

sciousness. They tend to disappear or to undergo favorable modification as the need for them disappears.

(4) The handicapping of an individual by either of these conditions becomes of primary social significance, and the solution of the perplexing problem lies in the field of mental hygiene.

(5) A definite and incisive therapeutic method came out of the management of war neuroses. Its efficacy can be measured by the large percentage of cured cases which were returned to active fighting conditions.

(6) Based squarely upon the theory of the mechanism of the war neuroses formulated above, preventive measures were put into operation by neurologists and psychiatrists actually serving with troops. This constituted a demonstration in mental hygiene, on a very large scale, which was so successful that the flow of nervous soldiers to the base was most effectually checked in the St. Mihiel-Argonne-Meuse offensive, with a great gain to morale and the immediate result of the return to duty, from the most advanced sanitary formations, of enough men to constitute a brigade of infantry.

Object of Therapeutic Method

The central notion of the therapeutic method consists in an attempt to influence a patient in such a way that he faces frankly and unafraid the conflict situation which has developed in his mind. He is taught that he must not depend upon instinctive processes of defense and protection, but must rely largely upon his ability to face his own problem and see it through. The effort to bring into active consciousness and expose to critical analysis of his normal mind the material automatically suppressed provides the means by which the individual can substitute a conscious for an unconscious defense.

A mere outline of this therapeutic idea scarcely can touch upon its future possibilities. Out of it should come a new therapeutic courage which, in the hands of trained and skillful neurologists and psychiatrists, should create therapeutic and prophylactic methods which directly and incisively attack the psychoneurotic manifestations at their source.

Conclusion

My concluding word is this: After every war the world tends to pass through a phase of reaction which is to be regarded as but the expression of the fatigue which grips a nation that has expended everything in the struggle. The hard-won gains of the war are often thrown away because of the apathy, weariness, intolerance, and fear of a tired people. Through such a period of transition, it is to be hoped that the fruits of the war experience in neuropsychiatry may be translated, unweakened and vitally intensified, into all of its civilian phases.

THE RELATION OF THE GENERAL PRACTITIONER TO THE NEUROTIC PATIENT

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THE neurotic person is *persona non grata* to the general practitioner, a source of annoyance, never promising the gratification that rewards successful treatment of disease. As a rule, no matter how hopeless a condition may be, it commands the general practitioner's interest, knowledge, and skill and stimulates his endeavor to help. This, however, is not his attitude toward the neurotic patient. The neurosis, to his mind, seems unreal, fantastic, and indeed presents no tangible problem. The so-called purely mental symptoms he regards as curious vagaries of the spirit, which in no way bear any relation to the actualities of life. Since the situation cannot be stated in terms of anatomy and pathology, he is prone to conclude that the problem is non-existent—that the complaints of the patient are an imposition upon his credulity, and that the entire situation presents an element of malingering. This preconception necessarily engenders in him a feeling of antagonism. From the beginning he lacks interest and sympathy, and feels that time spent with the neurotic patient is wasted.

How did such an attitude arise? What essentially has determined this preconception? The answer to these questions involves a serious reflection on our medical education. In spite of its many-sidedness, medical education to-day is in the main directed toward the mastering of special branches of knowledge, but lacks unifying coördination. It is because of this lack of unity that medical teaching is wholly given up to the study of disease phenomena, taking but little cognizance of the patient and his personality.

The student emerges from school filled to capacity with information about individual phases of the human organism, such as morphology, physiology, and pathology, but he has

not acquired the synthesizing point of view from which he can regard man as a whole, as an adaptive mechanism, the product of the forces of heredity and environment. His mind is possessed by notions of disease entities, which he seeks to recognize and combat. In a way, such a notion of malady is a direct heritage from the primitive medicine man, who conceived ailment as a thing apart from the afflicted, as an extraneous agency, as an evil spirit to be driven out. However, the modern doctor is not warring against evil spirits. His attention is concentrated mainly upon discovering pathological-anatomical entities. Although recently the idea of function versus morphology has begun to infiltrate medical sciences, nevertheless the physician has not yet attained the biological approach. This would enable him to consider all the phases of the human organism, not merely singly, but as a coördinated whole, thereby shifting the center of interest from the disease to the patient and his personal equation.

This lack of unifying coördination of the medical branches of knowledge, plus the concentration of interest mainly on the disease entity instead of on the patient, is a prominent feature of medical practice. But in the domain of mental anomaly there is an additional handicap. The fundamental essentials taught by modern pathology, which guide the general practitioner in all his other work, he fails to apply to mental patients.

One of the most valuable contributions of modern pathology is the present-day conception of inflammation, which is regarded as a defensive mechanism against noxious agents, be they bacterial or chemical. Inflammation is thus not a thing wholly foreign to the normal processes of the organism, but is, on the contrary, only a special rearrangement of the normal qualities of the body to meet onslaughts upon its integrity. Inflammatory processes do not differ from normal ones in kind, but only in degree. This conception represents a marked advance over old notions and is eminently significant for practical purposes. The modern therapeutist does not strive to combat inflammation. On the contrary, he coöperates with it, he facilitates it, in order to remove the offending cause, or, if such coöperation be unattainable, he seeks to adjust the organism to the condition in the best pos-

sible way. In short, disease phenomena are regarded as protective mechanisms.

Curiously, this conception of disease reaction is uncommon among medical men when the ailment is a mental one. The general practitioner has fallen into the habit of regarding everything mental as a thing apart from the organism, as something *sui generis,* as something subject to its own laws and purely of philosophical interest, not rooted, so to speak, in the actual being. Hence he has relegated this phase to the psychologist, the religionist, and the healer as something spurious and unworthy of consideration. He has completely missed the importance of mental symptoms as expressions of a maladaptation of the whole personality, represented by the entire biological equipment, mental as well as physical.

When, under the stress of the exigencies of life, the patient calls for relief at the door of the general practitioner, he may expect interest and assistance only for the weighable and measurable afflictions, but not for the heartaches and pains and complaints that are engendered by a crack or a break in the most important adaptive organ—mind. The physician has busied himself essentially with those organizations of the human mechanism which subserve certain more or less *fixed* types of reaction. He is well grounded in the knowledge of the normal and abnormal processes of respiration, of digestion, of neuro-muscular responses, etc., which have narrow limits of variation, and he overlooks the no less important aspect of what constitutes living—namely, the relation of the whole man to his environment, especially with regard to his fellow men. It is in this latter relation that there is the greatest room for variation of responses. There is but little difference in the way men breathe, walk, digest their food, but the ways are innumerable in which men respond to a demand or a responsibility of the social setting. It is common observation that some men respond to the social requirements better than others, that they do some things better than others, thus giving rise to the variations that constitute individuality. In the stereotyped functions of various organs we have the underlying organized mechanism, which to a great measure limits variation. In the higher activities of the human organism we do not meet fixed organizations that

circumscribe the responses to a rigid behavior pattern. In other words, the higher levels of man's nervous system are more loosely organized than the lower ones, and represent the highest effort of nature to bring about maximum variation, thus furthering adaptation and survival.

The highest degree of variation is attained in the mental processes. It is in the domain of consciousness that individuality is mainly represented, which, through its expression in behavior, operates for the good or the ill of the individual and his fellow men.

Social traditions, conventions, and laws are constantly converging their stress upon what we call the individuality, tending to limit it. They mold it, modify it, and endeavor to bring about a social pattern, which the individuality, because of its innate freeness, tends to escape. Just as the fixity of mechanism of a given organ tends to stereotype its function, so does the social mill tend to grind down the individuality to social uniformity. This struggle is the embodiment of the most significant phases of human living. It is indeed a conflict no less taxing than that involved in surviving in a jungle, in its wake leaving behind numerous victims, who are too weak to cope with the problem.

Some fall by the wayside completely devitalized in a social sense. These help to fill our hospitals for mental disease. Others place themselves altogether extra-socially, and feed upon the social body, not unlike parasites, refusing to identify themselves with the social structure. Their number, alas, is much too large in our penal institutions. But by far the greater number of victims of maladjustment are to be found neither among those who have fallen by the wayside into the oblivion of the hospital for mental cases nor among those who are warring against society, but rather among those whose life story is that of the neurotic. These are neither criminal nor insane. They have been washed out to the border lines by the swift current of life. They feel keenly that they are not in the main stream of reality, and long intensely to be a part of it. They find themselves too weak to steer their craft successfully, and in their frantic efforts to do so, manifest the neurosis as a substitute for real living. However, this surrogate is not an altogether comfortable companion. Deep in

their souls lurks the realization that somewhere there is a normal life, and they long for it. This brings them into conflict with their neurosis; they strive to free themselves from it, and without help they struggle and pine and complain.

Naturally this constant inner turmoil results in psychic ill-being, which the sufferer projects upon his body. The feeling of ill-being that streams into consciousness from diseased organs differs but little from this feeling of psychic ill-being—probably is identical with it. Man usually does not distinguish between psychic ill-being and that due to somatic disturbance, often interchanging these in his mind. When physically ill, he is unhappy, and, vice versa, when unhappy, he projects his unhappiness into symptoms of physical ailment, without any organic basis in the narrow sense. The neurotic headache, fatigue, tremor, cardio-vascular phenomena, splanchnic crises, are examples of such substitution.

In the light of such a conception, the neurosis ceases to be a curiously freakish form of mere perversity and rises to the tragic plane of a clinical expression of social-biological maladaptation. Its genesis, as in the case of all other life phenomena, is determined by two great factors—environmental influences and congenital peculiarity.

The following abstract of a patient's history may serve to illustrate some of the points I have been making: M. R., aged twenty-six, referred by a colleague, has been ill for eight years, his chief complaints being palpitation, sweating, feeling of inadequacy, fear of death, fear of insanity, impaired sense of reality. He has been under treatment by many physicians; from every one of them he carried away either reproaches for persisting in complaining groundlessly, or an assurance that his ailment was not real and that he would soon get well. But neither assurances nor reproaches tended to improve his condition. On the contrary, his suffering has recently become more intense, due to a superadded fear of insanity engendered by fancies regarding a pregnant sister. Examination revealed that he comes of a neuropathic stock, especially on the mother's side. He is the only son among three children and has always been pampered and overindulged by his mother, for whom he had an abnormal fixation. On the other hand, his relations with his father were marked by distance and

estrangement. The father was always austere and exacting. The atmosphere in which the patient was brought up was fanatically religious, permeated with the cabalistic mysticism so prevalent in Eastern Galicia. To the fear of demons and evil spirits engendered by his environment was superadded fear of the Gentile world, which he was taught was hostile and intolerant, holding but little comfort for a rabbinical student. Thus, at the age of thirteen, when he had to emigrate to America without his parents, he found himself hardly prepared to meet the exigencies of his new environment. Between the ages of thirteen and eighteen, while in this country, he was reticent, of limited social contact, and given to considerable introspection. His childhood thus laid the foundation for his present difficulties.

Sexually, there was apparently no awakening during the period of latency, but at the age of twelve he overheard the sexual congress of his parents. At the age of nineteen, upon the arrival of his family from the other side, he fell in love with his sister, a beautiful girl of fourteen, who much resembled his mother. She was blond, tall, and gentle. This attachment engendered a considerable conflict, for he clearly appreciated the nature of his emotion and its inconsistency with his religious tenets. For nearly two years, he fought against the lust and sought the solution of his difficulty by attaching himself to a girl, B, who most nearly reminded him of his sister. This attempt at transference from mother to sister, from sister to B, was not consummated. The parents of the girl broke up the relationship.

Thus this individual, abnormally fixed upon his mother in his childhood, wholly unprepared by his training and education to emancipate himself, abnormally conditioned in his fear reactions by mysticisms and race prejudice, was a fertile soil for a psychoneurosis.

The misanthropy and unhappiness that followed his last love experience drove him into closer contact with his mother. She became his only intimate companion. His sister by this time had married. The sister element continued to exert a potent influence upon his affective state, her engagement and marriage being curiously associated with exacerbations in his neurotic condition.

Purely as a matter of logical procedure, he decided to get married some six months ago, feeling quite sure that he would never love again and that it mattered little whom he married. His present wife is the very antithesis of his mother and sister. She is dark, short, and rather loud, but apparently fond of the patient. There has been a distinct aggravation of all his symptoms since his marriage, culminating in his present outbreak, which is by far the severest. It has been precipitated by his sister's giving birth to a child. As thoughts of impending dissolution would dart through his mind, he hoped that the newly born child would be named after him, as in this way he would continue to live by substitution.

It was marvelous indeed to note the tremendous change which the analysis of this man's history has wrought in his state. As he has gained insight into the situation, he has shed his symptoms, and at present is at work, free from complaints, having gained eight pounds in weight.

This case illustrates *par excellence* the importance of the environmental factor, of the social overload, and of a lack of insight into the production of a neurosis. It shows furthermore that nothing so tends to confirm a neurosis as does a lack of understanding on the part of the physician—understanding that is, of course, impossible without a psychological approach.

In the foregoing an attempt has been made to bring out the following points:

1. That the practitioner's attitude to the neurotic patient is essentially one of lack of interest and understanding.

2. That this is the result of a serious defect in our medical education, which is confined mainly to the study and treatment of fixed types of reaction and is devoid of the broad psycho-biological approach.

3. That the neurotic patient is to be regarded as a product of social maladjustment which is expressive of two important factors—namely, an inferior mental and physical equipment of the individual, plus a too great social load.

All this has been stated in the humble spirit of constructive criticism, and I clearly bear in mind the trials and difficulties under which most of the work of the general practitioner is

carried on. But it seems to me that a valuable addition to the armamentarium of medicine could be obtained if the general routine physical examination of a patient were followed by a thorough psychological and social analysis; that a consideration of heredity should not be confined merely to the investigation of occurrence of such diseases as tuberculosis, cancer, syphilis, but should also seriously devote itself to obtaining psychological data regarding such matters as education, morals, economic levels, the character of the psychic atmosphere in the home as registered in the relation between various members of the family—father to mother, brothers to sisters, and both to parents, etc.; that it is not enough to know what infectious diseases the patient has had as a child—it is at least as important to understand how he was conditioned with regard to his parents, who represented his first social contact. What was their attitude toward him? Was it one of undue discipline? Was it one of overindulgence? Or was it one of indifference? What special experiences have marked puberty and adolescence? What was the relation of the patient at that time to his associates of the same and of opposite sex? What was his attitude to his education and to his vocation? Was the latter a natural expression of the patient's leanings or was it dictated under the pressure of necessity? What is his sex life? Is there any difficulty in adjustment there? What is the marital relation? Does the latter facilitate adjustment or does it add or generate difficulties? Not least in importance is a determination of the mental capacities of the individual as determined by psychometric measurements. In short, the physician should seek to establish the entire psychic past, which, cumulatively, is exerting its influence upon the sufferer.

Having obtained these data, the physician would have a reasonable approach to what constitutes the innate shortcomings of the person as well as to the special condition which tended to accentuate them. The therapeutic indications then become in a general way clear. The patient is to be given a thorough insight into the entire situation. He is to know himself as well as possible, and he is also to be taught how to avoid the overburdening of his weaknesses. A perfectly candid discussion of the problem is the procedure of choice.

The patient need not be beguiled into complacency by a denial of his shortcomings. No promise should be held out of a cure in the sense of a restoration to the level of the normal. He should be taught to see clearly that there are certain things he may not be able to do, and that there are others in which his capacity will have the best chance.

The neurotic patient as a rule has an untempered vision of unattainable ends together with a profound feeling of inferiority, both of which must be discouraged. He must learn that his mentality can never be an imposing edifice—that it is only a modest cottage which he has neglected in his dreams about palaces. In this neglect he has overlooked the necessity of a proper hygiene; he does not keep the cottage clean, free from cobwebs and dust, and does not allow the fresh air of reality to enter it. In short, he has lived mentally unhygienically.

ELMER ERNEST SOUTHARD

THROUGH the death of Dr. Elmer Ernest Southard of Boston, Massachusetts, who died in New York City, February 8, after a few days' illness from pneumonia, mental hygiene loses one of its most active and most stimulating workers. At the time of his death, Dr. Southard was attending the Third Convention of Societies for Mental Hygiene, where his paper *Trade Unionism and Temperament; Notes on the Psychiatric Point of View in Industry,* read at the opening session, was one of the important contributions of the Convention.

Dr. Southard was forty-three years old. He was born in Boston, the son of Mark and Olive Wentworth (Knowles) Southard of Maine. He graduated from the Harvard University Medical School in 1901, having previously (1897) received a degree in arts from Harvard University. In 1902 he received the degree of Master of Arts from Harvard and in 1917 Georgetown University conferred upon him the degree Doctor of Science. During his work in the university, he specialized in philosophy under Professors William James and Josiah Royce, and for a period conducted Professor Royce's logic seminar. He always maintained his interest in philosophy, and his later writings on mental hygiene are replete with references to the work of James and Royce. The week previous to his death he had been invited by the university to collate and edit the works and manuscripts of the late Charles Pierce, a piece of work to which he looked forward with great interest.

On the completion of his work in the medical school, Dr. Southard went to Europe, where he studied at Senckenberg Institute (Carl Weigert, Director), Frankfort, and at the University of Heidelberg (Kraepelin's clinic and Nissl's laboratory). On his return to the United States, he became instructor in neuropathology at Harvard; later, assistant professor; and, since 1909, Bullard professor of neuropathology. He became head of the Department of Nervous and Mental Disease of the Harvard Medical School in 1913 and retained

the position until his death. He was assistant visiting pathologist of the Boston City Hospital in 1904 and 1905; assistant physician and pathologist of the Danvers (Massachusetts) State Hospital from 1906 to 1909; pathologist of the Massachusetts Commission on Mental Diseases in 1909; and director of the Boston Psychopathic Hospital from its opening in 1912 to 1919. At the time of his death, he was the director of the Massachusetts Psychiatric Institute of the Massachusetts Department of Mental Diseases. He was chairman of the Section of Neurology and Psychiatry of the American Medical Association; president of the Boston Society of Neurology and Psychiatry; president (1918-1919) of the American Medico-Psychological Association; a director of the Eugenics Record Office, Cold Spring Harbor, New York; a member of the board of scientific directors of the Bedford Hills Laboratory, Bureau of Social Hygiene, New York; a member of the Committee on Psychiatry of the National Research Council; a director of the Massachusetts Society for Mental Hygiene; a member of the National Committee for Mental Hygiene, with memberships on its former subcommittees on War Work, the Smith College Training School for Psychiatric Social Workers, and the present Committee on Education. He was a member of the editorial board of the *Archives of Neurology and Psychiatry,* and an associate editor of the *Journal of Nervous and Mental Disease,* the *Journal of Clinical and Laboratory Medicine,* the *Journal of Abnormal Psychology,* and the *Bulletin of the Massachusetts Commission on Mental Disease.*

During the war, Dr. Southard was director of one of the United States Army neuropsychiatric training schools, and later a major in the Chemical Warfare Service. The request of the chief of the Chemical Warfare Service that he accept a commission in that branch of the army came as a surprise to Dr. Southard, but was a compliment that he appreciated. His services were desired, not in the capacity of physician or neuropsychiatrist or pathologist, but as a philosopher and thinker. The problems to be put to him concerned broad policies of strategy. Dr. Southard was under overseas orders at the time of the armistice.

In his pathological work, Dr. Southard had devoted par-

ticular attention to the study of dementia praecox and feeblemindedness. He published a number of monographs on the subject of dementia praecox and, in collaboration with Dr. Walter E. Fernald, Superintendent of the Massachusetts School for the Feebleminded, a large volume was published in 1918 containing an elaborate and careful study of the brains of ten feebleminded patients. This volume was the first in a study planned of one hundred cases. The second volume was in the course of preparation at the time of his death. With Dr. Harry C. Solomon, he published, in 1917, *Neurosyphilis,* a case book. His latest book, *Shell Shock and Other Psychiatric Problems,* a case book dealing with neuropsychiatric problems of the war, was issued in 1919. The manuscript for a third book on psychiatric social work, written in collaboration with Miss Mary C. Jarrett, was about ready for the publisher at the time of his death. In June, 1919, Dr. Southard was given a commission by the Engineering Foundation, New York City, to study the mental-hygiene problems of industry. His preliminary report on his work was made to the Foundation in December and is published in the January (1920) number of Mental Hygiene.

This report was followed by two papers on the mental hygiene of industry, *Trade Unionism and Temperament; Notes on the Psychiatric Point of View in Industry,* (Mental Hygiene, April, 1920) and *The Modern Specialist in Unrest; a Place for the Psychiatrist in Industry,* (Mental Hygiene, July, 1920).

Dr. Southard was a man of broad interests, and although in medicine engaged first as a pathologist, the philosophical and social aspects of his profession and specialty were of great interest to him. He will be remembered not alone as a pathologist, but as a leader in the development of the field of the psychopathic hospital and the field of mental hygiene, and for his training and stimulation of younger men and women.

ABSTRACTS

Mississippi Mental Deficiency Survey, 1919. By Thomas H. Haines, M. D. Report of the Mississippi Mental Hygiene Commission. 45 pages.

The Mississippi Mental Hygiene Commission, appointed by the governor in 1918, has recently published a report of the mental-deficiency survey of the state conducted during 1919 by Dr. Thomas H. Haines, of the National Committee for Mental Hygiene.

"The feeble-minded," Dr. Haines states in the introduction of the report, "are those who have by natural endowment so little sense that they cannot manage themselves and their affairs with ordinary prudence. Their bodies grow up—they have all the instincts of adults; their minds, however, remain those of little children. Any community which disregards these facts and treats the feebleminded as harmless fools, allowing them the privileges of citizens, reaps the result of this disregard in two general forms of expense: (1) The feebleminded are parasites on society. They are dependent both as children and as adults. They live in orphanages and poor farms, and by other public and private charities; or they are delinquent, actually preying upon society—killing, burning, stealing, and spreading disease. (2) When these parasitic shallow-wits are allowed to follow their own unmoral and ill-controlled inclinations, they bring into the world large numbers of feebleminded children, the birth rate of the feebleminded far exceeding the average. Future taxpayers' expenses are thus multiplied.

"Mississippi has made no provision for obviating either of these forms of expense imposed by the feebleminded. She is now one of only eight states that provide no state care for their mental defectives. Her population constitutes 29 per cent of the population of these eight states. Within the past year Tennessee, Florida, Georgia, and Alabama have instituted such state care. Mississippi can ill afford to continue her present wasteful neglect of these parasites. It is the object of this report to point out some of the economies that can be effected by making provision for their training and segregation."

A study of the state statutes showed that they "fail to distinguish clearly between (1) those who are mentally ill, and some of whom recover under proper treatment; and (2) the feebleminded, who lack capacity because their brains have not developed. The *feebleminded do not recover,* but they can be *trained to work,* and, when properly trained, will *do much toward their own support.*

"The statutes also fail to provide against the danger (1) of *crimes of the feebleminded,* and (2) of the *rapid multiplication of defectives.*"

Of the 62 poor farms in the state, Dr. Haines visited 38, with an aggregate population of 385, over three-fourths of the total poor-farm population of the state. Of these 385 persons, 141, or 36.6 per cent, were feebleminded.

"Most of these counties own the poor farms, and the interest on the investment must be considered as a part of the cost of maintaining the feebleminded paupers. It costs boards of supervisors from eight to fifteen dollars per month for food and fuel for each of these poor-farm inmates. Clothing constitutes an additional expense. The contract rates are increasing. A conservative estimate of county expenses for the maintenance of feebleminded paupers actually in poor farms is $38,000 annually.

"In many cases the physical care, in the way of food, shelter, and clothing, is not good. In no case is the poor farm providing training for the feebleminded. This is not considered a part of the business of the keeper of the poor farm. Because they are not trained, the feebleminded at poor farms are not producing as they could and should. They would also be happier if they were working.

"But the most drastic criticism of poor-farm care of the feebleminded is that little precaution is taken to prevent propagation. The feebleminded in large measure come in families; mental deficiency is transmitted from generation to generation. Cases belonging to families in which mental defectiveness is frequent are found at almost every poor farm. In one case, two sisters, in middle life, have been in the poorhouse fifteen years. One has the mind of a child of about four years of age, and the other that of a five-year-old. A twin brother of one of these women, and another brother, are reported to be of like mentality. The sister of five-year-old mentality is constantly importuned by an old man, another inmate of the same poorhouse, and also feebleminded, to consent to marry him.

"Another county poor farm is maintaining twin sisters and a brother who have been there eighteen years. No one of them has the mind of a child above six years of age. All are past sixty in life age. Two other feebleminded members of the same family, now dead, came to the poorhouse eighteen years ago. Three other members of the family, already dead at that time, are reported to have been mental defectives.

"Far from preventing any further propagation of these unfit stocks, the poor farm is actually a direct agent in aiding such propagation. In the course of my visits, I found eight married couples,

feebleminded persons, living in the poorhouse, most of whom had been married since they had been living upon the public purse, some of them by and with the consent of the board of supervisors and the superintendent of the poor farm. Seven of these couples are white persons. One of the feebleminded females married at the poor farm was herself born there forty-two years ago, and her father is own brother to her mother. The mother still lives at the poor farm.

"In many cases, feebleminded illegitimate children are born to feebleminded mothers in county poor farms. One white woman in middle life, who has been on the county for twenty years and whose mentality is that of a five-year-old child, has borne, out of wedlock, upward of half a dozen children, some white and some black. Another young white woman, who was herself an illegitimate child, born in the poorhouse, is the unmarried mother of three children, and the father of two of these children is reported to be a feebleminded syphilitic, at present in the poorhouse."

Besides these 141 feebleminded, Dr. Haines found, in the 38 poor farms visited, 13 epileptics, 46 victims of mental disease, 36 blind, and 14 deaf persons, none of these unfortunates receiving the treatment or training demanded by their condition. Also, some 15 men and women were found who were judged to be quite capable of self-support, and 37 others who were sick and in need of hospital care.

"Making these deductions of the feebleminded, the insane, the epileptic, the blind, the deaf, the sick, and the able-bodied who should not be receiving county aid, we have remaining only 98 in the poor farms visited who are properly classed as old and infirm, honest citizens, worn out with work and unfortunately not possessed of sufficient competencies to support themselves. These are the proper recipients of county aid, the persons for whom the poor farms were designed.

"Manifestly, it is poor economy for the 82 counties of Mississippi to maintain 62 county poor farms for twice that many persons. Furthermore, there are few cases in which the county poor farm gives a square deal to the proper inmates, as above described. These old, worn-out, and deserving poor would be better provided for, and at less expense to the state, if a few inter-county or district infirmaries were provided. When the mentally and physically ill and the feebleminded are taken from the poor farms, many counties can ill afford to maintain the present inefficient arrangements for paupers. Provision should be made for infirmary treatment of the old and infirm."

Forty-three county jails were visited, including the jails of all the most populous counties. These jails had a total population of 255—59 whites and 196 negroes. One hundred and forty-four of these 255—less than one-half—Dr. Haines judged to be neither feebleminded,

epileptic, nor mentally diseased. Forty-four were feebleminded—over 23 per cent of the total jail population visited.

"These persons are delinquents primarily because they are not gifted with common sense enough to manage themselves according to law and the social proprieties. By nature they lack sufficient imagination to realize what the rest of us feel and think and will do about their offensive conduct. They cannot, therefore, prevent their own delinquencies in the future, no matter how much they are punished or how long they are detained. Punishment of the feebleminded does not effect a reformation.

"In a central Mississippi county jail I found a brutal-looking negro, much of the type of Millet's 'Man with a Hoe,' accused of killing a white man who worked on the same plantation with him. His expression was, 'Some white people fooled me up to kill him,' and his defense was that if he had not killed the white man, they would have 'fooled' the white man 'up to kill' him. This 'boy' was twenty-five years of age, apparently. He had no knowledge of his age. He told the manner in which he killed his victim just as an ordinary man would speak of killing a hog. He had very little conception of numbers or of time; he had no idea of the value of a bushel of corn, the time when Christmas comes, or the number of nickels in a dollar. His mental age was less than eight years. He killed the man for five dollars, which he did not receive. This fellow and his crime constitute an illustration of the *easy suggestibility* of the *feebleminded,* and how they are made the tools of designing persons. Clearly, the best procedure in the way of protecting ourselves against such crimes is to *detect the feebleminded before they commit crimes* and place them where they will be unable to do harm to themselves or others.

"In a county jail in the Delta I found a white man of about forty, who was accused by his wife of having immoral relations with their little daughter. This man is unable to name the months of the year, and has no idea what leap year is, or how many days there are in February. He is not a case of illiteracy simply; he is illiterate and ignorant because *he has not the capacity to learn.* His *nervous system* has *not developed,* and this is the reason for his being a *fool.* This is also the reason for the offense of which he is accused. Society should protect itself against the reproduction of this class of citizen by taking into custody such defectives, giving them opportunity to make their livings, but taking precaution that they shall not marry or otherwise assume the duties of parenthood. This man has a large family, and that they are like himself is proved by the presence of his oldest, a sixteen-year-old boy who is voluntarily staying in the jail

with his father. Upon examination, this boy proved as defective in intelligence as his father.

"A burly old chap of sixty-five was found in a north Mississippi county jail, charged with contempt of court. His expression was, 'They have got me in here for attempting court.' The old fellow is clearly a defective of less than nine-year intelligence. The facts seem to be that he proved such a nuisance to his wife, who had borne him eleven children, that the court granted her immunity from his presence. She had been managing a farm quite successfully, with her children, but he would not stay away from her. He had destroyed her prosperity by his insistence upon visiting his family, and was expected to prove an impediment to his wife and children as long as he could get at them.

"A negro boy of fifteen was found in a south Mississippi county jail, accused of horse stealing. The boy stated that he had been enticed over into a field where a man had a young mare, and the man told him that if he would take the horse and sell it, he could have half the proceeds. With this assurance, he rode thirty miles to Jackson and offered the mare to a livery man for $75.00. At the livery man's suggestion, he then offered her to the sheriff. The ingenuousness of his story, and of his conduct, led at once to a suspicion that the boy was short-witted, and conversation with him confirmed this suspicion. He was not only ignorant; he was feebleminded. He had very little idea of the value of money, and his ideas of time were those of a child of about seven years of age. Sending him to the penitentiary could not reform him, because he lacked the elements of understanding by which he could conceive of its being wrong to take the property of another person. A lad as suggestible as he would as easily commit murder as the twenty-five-year-old negro above mentioned. He is a ready tool for designing persons. Society can best protect itself from his depredations by placing him in custody, and giving him the best *possible opportunity to make his own living under supervision.*

"A white man about forty-five years of age was found in a south Mississippi jail, accused of rape. He had assaulted the little daughter of the man who had befriended him, and in whose home he had lived upwards of two years. Apparently he had never worked for wages. He was unable to tell the time by a watch, to count money, to answer simple comprehensive questions which eight-year-old children usually answer, to draw a diamond-shaped figure from copy, or to repeat five figures. By actual measurement by the Stanford-Binet scale, his mentality is that of a child of six years and eight months. This man has been sent to the penitentiary because Mississippi has no colony or home for the segregation of the feebleminded. The peniten-

tiary cannot do anything that will make him less liable to commit crime. He should never be at large. He cannot acquire the capacity for exercising the rights of citizenship, and living up to the responsibilities thereof. Such a mind as his should constitute him *a lifelong ward of the state.* . . .

"The jails visited constitute about one-half the county jails in the state. They represent a 'run-of-the-mine' of jail populations. We must remember that the mine is operating constantly. The 44 feebleminded actually found in jail, therefore, represent only a part of those who would be in these same jails in the course of a year. It is safe to assume that there are 200 feebleminded who pass through the jails of Mississippi every year. . . .

"There are probably 100 feebleminded in the jails of Mississippi continuously. Mere board for these costs $21,000 a year. Clothing, bedding, fuel, water, and wear and tear on jail buildings add another $10,000. Salaries of judges, sheriffs, deputies, clerks, and jailers, in so far as these officials give time to feebleminded offenders, cost the state $40,000 a year. Juries and witnesses for trials of the feebleminded cost $20,000. Several of the feebleminded in jail are murderers. A productive citizen is worth at least $6,500 to his dependents. Other feebleminded ruin lives and destroy property. The criminal destructions of the feebleminded cost Mississippi $40,000 a year."

No complete mental survey was made of all the inmates in the state penitentiary, as the penitentiary population is located at ten widely separated points. Two groups of convicts were examined, however—one of 101 white males and the other of 622 negroes, 31 of them women. Group intelligence tests like those used in the army were given. In the case of the first group, those who were suspected of mental deficiency were called up for individual examinations. Forty-four of these 101 white men were thus examined individually. Nineteen of these were classed as feebleminded and 7 more as of border-line intelligence.

"Some of these border-line cases should, in view of their repeated delinquencies, be considered defectives, because they have shown themselves to be incapable of managing themselves and their affairs.

"*Lifelong custody* is the *only suitable management* for 25 per cent of these white males in the penitentiary. The Mississippi State Penitentiary manages them in a very suitable manner as long as they are under its control. While, however, the courts, the pardoning board, and the governor do not recognize that their short-wittedness cannot be made good by any species of penitentiary discipline, and, therefore, do not realize that they should not be pardoned, paroled,

or discharged, the state and the community to which they are returned are subjected to the menace of repetitions of their crimes. *No feebleminded convict should be subject to pardon, unrestricted parole, or release* upon the termination of his sentence. We must learn to look upon these grown-up children as in need of guidance as long as they live, no matter how many gray hairs or other signs of dignity they may come to exhibit."

Forty-one per cent of the 622 negro convicts examined were estimated to be feebleminded.

A mental survey was made of the entire population—128 children—of the Mississippi Industrial Training School. The same method was used—first a group intelligence test and then individual examinations of the lowest scorers. Thirty-eight of the 128 children were called up for individual examinations because they scored as low as the lowest 2 per cent of public-school children of similar ages. Ten of these 38 were classed as feebleminded and 5 others as border-line cases.

"Assuming that half of the border-line cases will eventually prove to be feebleminded, we have about *10 per cent of this population* appearing to be so defective in intelligence that we cannot reasonably expect them to *develop* into *responsible and productive citizens.* . . .

"This school is expected to take dependent and delinquent boys and girls, and develop them into citizens. In so far as this feebleminded 8 or 10 per cent of the children are concerned, *an impossible task has been imposed upon the industrial school.* These children lack the nervous-system development necessary for the kind of character that citizenship requires. To make citizens of them, therefore, is a superhuman task. They were created with defects which no kind of education or training can make good. In the interests of the children who are not defective, in the interests of the successful operation of this happy addition to the institutions of Mississippi, and in the interests of the citizenship of the state generally, it is highly important that the Mississippi Industrial Training School should be relieved of the care of mentally defective children."

It is equally important that the state orphanages should not be burdened with the care of feebleminded children. One of the unfortunate consequences of having them there is that they are sometimes chosen for adoption, the foster parents being ignorant of the fact that they are incapable of normal development.

"The *feebleminded child in the orphanage is more out of place* than is the feebleminded convict in the penitentiary. *Psychology* should be called upon to *detect* these *incapacities* for mental development. Orphanages should be *saved the misappropriation* of their funds to

the *bringing up of such impossible citizens.* Foster parents should be *saved the disappointment* which is bound to be theirs when they find that the pretty little child has not a mind corresponding to the smile on his happy face."

The Mississippi survey included two large orphanages, one with 140, the other with 130, children. These were surveyed in the same manner as the Industrial Training School. About 16 per cent of the children in the first and 17 per cent of the children in the second were diagnosed as feebleminded or of such low intelligence as to prove, in all probability, incapable of holding their own in normal society.

"These are only two of the six orphanages in the state. There are about 600 children in the six orphanages. Assuming that 16 per cent of these are feebleminded, as found in a careful survey of nearly half of such a population, *the orphanages of Mississippi are sheltering at the present time well on to 100 feebleminded children,* at an expense to the normal childhood of the state not only of the food, shelter, and training facilities which the feebleminded children are using, but by an actual hampering of the educational progress of the normal children with whom they are placed."

No exact mental measurements were made of the children at the Institute for the Blind or at the Institute for the Deaf and Dumb, but from the reports of the superintendents and from his own observation of the children, Dr. Haines concluded that 6 among the 50 pupils at the former institution and 8 among the 124 white pupils at the latter were so defective in intelligence that they were not only incapable of profiting from the expensive education that was being given them, but were hampering the training of the pupils of normal intelligence.

One girl seen at the Institute for the Blind has a father, a grandfather, and a great-grandfather all blind. One brother is a thief and another is mentally diseased. "Such a case indicates the need of a state board, headed by a psychiatrist, with power to have registered such unfruitful lines of the population and to exercise control to prevent the multiplication of these potential paupers and criminals. It is as important to have some agency in the state empowered to stop such a line of human stock as it is that the county agent should get the farmers so to improve the dairy cow that richer milk shall be produced."

The two state hospitals for mental disease, with a total of 2,233 patients, reported, on February 1, 1919, 123 feebleminded patients and 164 epileptics. Many of these latter, Dr. Haines states, should primarily be considered feebleminded, since their epileptic attacks

are incidental to the defective condition of their nervous systems; probably half of them would be more properly cared for in special cottages at a colony for the feebleminded than in the wards of these hospitals for mental disease. None of the feebleminded should be cared for in these hospitals.

"The work of training the feebleminded, of keeping them segregated, and of preventing their multiplication in the community, is quite distinct and separate from the work of diagnosing and treating mental disorders. Even if the hospitals had the room to care for 1,000 feebleminded, it would be unwise to mix up these problems with those proper to the hospital. The custody and training of these persons should be taken in hand by an institution especially designed to handle such cases, and the hospitals for the insane should be left free to organize themselves more effectively for the treatment and prevention of mental disorders. They could then care for the one hundred and more insane negroes now lying in jail in various parts of the state, for the reason that the hospital at Jackson cannot receive them. They could take all the insane from the poor farms. The medical staff of each institution could then be organized to do more scientific work in its own special field. The *hospital for the insane* has a large field in *preventive medicine.* It should be studying the problems of insanity with a view to *preventing* many of the *cases that occur at present,* and thus lessening the burden of the state in its care for the mentally deranged."

A thoroughgoing mental survey was made of the school population of the city of Jackson, the group-intelligence-rating method being used first, and the lowest 2 per cent in each life-age group being called up for individual interview and examination.

"Many children were examined at the request of teachers. As a result of these individual examinations, 15 *white children* were found to be *feebleminded.* These children were judged to be feebleminded not only on the ground of the results of the examination, but from the facts learned through teachers as to school activities, environments, and personal histories. There appears no reasonable doubt, in the case of any one of these 15 children, that he will be unable to make his living in competition with his fellows, and to manage himself and his affairs with prudence.

"In addition to these 15 feebleminded found among the 1,555 white children actually present in school on the days when the group tests were made, there are eight other feebleminded in the city who are of 'educable age.' Three of these have never been in school; four others are, or have been, in the Institute for the Deaf and Dumb.

"*Twelve other children* of the 99 given individual examinations in

schools made intelligence quotients from .65 to .76, and from these facts, taken together with the facts of personal history, family history, and educational progress, as well as observed physical conditions, were adjudged as of *border-line intelligence.*

"It will thus be seen that the children adjudged feebleminded actually found in grades one to seven, inclusive, constitute 1 per cent of the actual attendance at school on given days. The 1,555 attenders constitute about three-fourths of the white school registration (2,200), and about one-half of the white persons of the city who are classed as 'educable' in the school census (3,133).

"The 23 feebleminded white children found in the city constitute .73 per cent of the 'educable' white children in the district (7.3 per thousand), and over 1 per cent of the registered white children. . . .

"The State Superintendent of Education reports 791,585 educable children in Mississippi. Seventy-three hundredths of 1 per cent of this number is 5,778. There are nearly 6,000 children in Mississippi, many of them in the public schools, who are feebleminded. Many other border-line cases and dullards cannot progress in public-school work. Probably 9,000 children in the state are *so poorly endowed with common sense and powers of imagination that they cannot profit by ordinary grade work.* This is a conservative estimate. Not all of these children demand colony care. Many can doubtless be cared for in their homes. But every one of them is a hindrance to the education of the normally endowed children in the same school, and is himself *not getting a square deal* from the school. His handicapped mind can be developed only by educational methods which emphasize concrete situations and mental work. These defective nervous systems can be developed to their fullest capacity only by the exercise of muscles, by learning muscle coördinations—learning how to do things about the home and the farm.

"These feebleminded and border-line cases actually found in the schools of the city of Jackson show the need of opportunity schools in this city. There should be two rooms in Jackson devoted to the needs of these special cases. They would take these special cases out of the schoolrooms, where they are hindering the progress of normal children, *and give them the only training they can utilize.* Every city school system, and many consolidated schools, should have like opportunity or special rooms, where manual training of various sorts would constitute the chief method and means of mental development.

"When, however, the public schools have been developed to the point of the highest efficiency for meeting the needs of handicapped children, there still will remain considerable numbers, even in urban centers, which can be properly cared for only in state institutions.

In many rural districts, the state institution will remain the only recourse for the proper training and custody of the feebleminded child.

"The present expenses for the education of feebleminded children in the public schools of Mississippi are difficult to estimate. No one is responsible for assembling the costs of public education. The last annual state appropriation was $1,985,895. One per cent of this is about $20,000.

"Some counties have no county levies for educational purposes. Other counties have county levies amounting to three times the amount of the state appropriation received by the county. In addition to this, there are various municipal and consolidated school district levies for educational purposes. In a general way it seems safe to assume that the total amount of county and other local levies for educational purposes in the state, and the poll taxes, equal the state appropriation for the public schools. So we may consider that another $20,000 is already spent upon the education of mentally defective children.

"This $40,000 spent by the public schools upon the education of feebleminded children would be economically expended for special or opportunity schools, definitely planned to give these children training for that sort of limited citizenship which the conditions of their equipment permit."

In closing Dr. Haines again emphasizes the hereditary nature of feeblemindedness and the vital importance of preventing the propagation of the mentally unfit:

"We have shown that these people are being supported by the public at an annual expense of $296,000. This great expense is in no wise taking into account the hereditary character of the defects that make these people parasites upon the good citizenship of the state. The money goes out to them simply to relieve their present wants, and provide temporary care. These expenditures are makeshifts. They are not intelligently planned. As this money is expended upon them, it simply *enables them to exist in better fashion* than they could without this aid, and it *increases the next generation of dependents, and feebleminded criminals and prostitutes.*

"It is highly important that steps be taken to *turn this vast present expenditure on account of the feebleminded to such uses that it will prevent the propagation of the mentally unfit.*"

As to what these steps should be, Dr. Haines makes the following suggestions:

"(1). The beginning of the application of science to this situation clearly consists in the establishment and organization of a *state colony and training school for the feebleminded.* Such an institution is

urgently required for the feebleminded children now with orphanages and with child-placing agents; for many children in the public schools; for improperly guarded young females in both poorhouses and jails; and for feebleminded offenders of both sexes, wherever found.

"Sterilization has been proposed as a means of preventing propagation of the mentally unfit. No state has yet found this a practical measure for the handling of any considerable number of its feebleminded subjects. Even if this means is adopted, the institution for the training of the feebleminded, and for the segregation of those socially dangerous, will constitute the necessary means of carrying out sterilization measures.

"We have, therefore, the evident need of the institution. We have, also, the example of some states which have been at work on these problems for seventy years. Mississippi cannot afford longer to delay taking up this matter.

"As indicated above, the funds necessary to operate the colony and training school for the feebleminded are already being expended, to the extent of over a quarter of a million dollars annually, in the inadequate and inappropriate handling of feebleminded persons. An appropriation to establish and operate a colony for the care of the feebleminded in the state will not mean the imposition of a new expenditure upon the state; it will mean merely a *rational redirection of present expenditures.*

"(2). The next step in a state policy for the intelligent handling of the feebleminded will be the *organization of special opportunity schools* as a part of the public-school system. These schools will emphasize *training of the nervous system through the hands.* The feebleminded can learn to do many things which will enable them to contribute to their own support, and happily the learning of these things is at the same time the best method of developing their nervous systems and making of them the most adequate possible human beings under the limitations with which they are born.

"(3). The next step in the solution of these problems involved in our mentally defective population consists in the organization of *mental clinics.* Every school, every court, and every social agency should have at its disposition *medical and social* service which understands mental deficiency, and which can give to the schools, courts, and social workers, as the result of thoroughgoing examinations, not only a diagnosis and a prognosis, but competent advice as to treatment. The medical staff of each of the hospitals for the insane, and of the colony for the feebleminded, when organized, should be provided with the time and with the funds to enable them to make visits

at stated times to the principal centers of population of the state, for the purpose of making these examinations and giving advice as indicated above.

"The *hospitals for the insane and the colony for the feebleminded should be completely divorced from partisan politics.* They should be organized under *one board,* with a *state psychiatrist* as its director. With such organization, the hospitals could do real scientific work in examining and treating patients. This would result in many more recoveries and save much present economic loss to the state.

"Organized on a scientific basis, the three institutions for mental cases could arrange to hold clinics both in the cities in which they are located and at other places over the state, and could thereby not only afford relief by diagnosing and prescribing for psychopathic and feebleminded and peculiar subjects in schools and courts, but would perform a genuine service in actually *preventing many persons from developing threatened insanity and also in preventing the multiplication of the feebleminded.*

"Such an *extension of preventive* medicine in the *realm of mind* would mean a *tremendous saving of productive citizenship* for the state of Mississippi.

"(4). Finally, a system of *state registration and supervision* of all mentally defective persons is the goal toward which we should constantly strive. Not until some central authority, like a commission for the feebleminded or a department of the State Board of Health, with a psychiatrist in charge, is given authority and funds to make such a survey and registration of defective stock throughout the state, and also power to control mentally defective persons so that they shall not commit antisocial acts, and especially shall not bring feebleminded children into the world, will the state have taken really effective hold of the problems involved in mental deficiency, and be in a position effectually to diminish, year by year, the expenses arising from mental defects.

"Many feebleminded persons, and families of feebleminded persons, can be successfully managed outside of institution life and segregation, where there is a competent authority to exercise supervision and control over them. In order to control them, *the supervision must be rigid.* This involves *frequent visitation.* This is expensive, but after all such extra-institutional control is cheaper for some paroled patients, both insane and feebleminded, and for some who are never sent to institutions. Such a board of control of mental cases would have to work in closest relations to the institutions, and also with the public schools, courts, and other social agencies."

After-Care Study of the Patients Discharged from Waverley for a Period of Twenty-five Years. By Walter E. Fernald, M.D. *Ungraded,* 5:25-31, November, 1919.

Dr. Fernald gives here the results of a survey, made in 1919, of the patients discharged into the community from the Massachusetts School for the Feebleminded at Waverley during the twenty-five years from 1890-1914 inclusive. A circular letter was sent to the relatives or friends of these patients, asking for their coöperation in the gathering of information, and this was followed up by a visit from a social worker, who talked with the family, the pastor, local officials, the police, etc. The information obtained was checked up from several sources in each case.

"The total number of discharges for the period was 1,537. Of this number 891 were not considered in this inquiry for the following reasons:

187 were directly transferred to other institutions for the feebleminded;

153 were directly transferred to hospitals for the insane;

89 were directly transferred to hospitals for epileptics;

8 were directly transferred to other custodial institutions;

175 from other states had been sent to those states;

279 could not be located.

"This left 646—470 males and 176 females—whose history in the community could be obtained. Of this number 54 males and 24 females had died, and 68 males and 33 females had been re-admitted to the school.

"The relatively small number of discharges for so long a period, with an average number present ranging from 640 in 1890 to 1,660 in 1914, shows that the policy of long-continued segregation was consistently followed during the entire period. We honestly believed that nearly all of these people should remain in the institution indefinitely. Some were allowed to go because they seemed to have no vicious tendencies, and their friends were intelligent and able to look out for them, but the majority were dismissed under protest. Not a few of the males took matters into their own hands, and ran away. Those who could not be located were largely the children of recently arrived immigrants in the large cities.

"Of the 176 female cases where the history could be obtained, 27 had married, and there were 50 children; 17 children had died and 33 were living. The social worker saw nearly all of these children, and was not sure that any of them were defective. Seven of the married women had no children. Nearly all of the women had married men whose social status was rather above that of their own parents.

"Eleven married women were living useful and blameless lives; had neat and attractive homes, bore good reputations in the community, went to church, and apparently were making good in every way. All but one of the married women were morons. One was an imbecile, and her marriage had, of course, turned out badly. These 11 women had 34 children, all of whom seemed normal. Of the 11 successfully married home-makers, 3 were discharged without protest, at the request of responsible relatives; 8 of the group seemed so unpromising that they were not allowed to go from the school until their discharge was ordered by the Supreme Court on a writ of habeas corpus; all of the group of 11 were apparently definitely feebleminded. All had been immoral before admission, and at first, after their admission to the school, were troublesome on account of their active sex interest. After their discharge and previous to their marriages they had apparently behaved themselves and had earned their own living.

"Of the 16 married women who are behaving badly, every one was discharged against our judgment, and only after a long contest and the use of powerful political influence; in 9 cases, the courts ordered the discharge. In these 16 unsuccessful marriages, the women turned out about as we had predicted, with a record of sex promiscuity, alcoholism, thievery, etc. Four women had syphilis. None of them conducted a decent home. In all, they had 24 children—1 woman had 10 children; 1 married moron, who had 2 children, and 1 who had 6 children were subsequently returned to the school. Both had been taken away from the school by town authorities, under strong protest.

"There were 11 unmarried mothers among the 176 discharges, and there were 13 illegitimate children in all. Of these mothers, 8 were morons and 3 were imbeciles. Eight of these women were returned to the school after childbirth. Every one of these women was exceedingly troublesome while at the school, and all were discharged only after a long contest. Not one of them had relatives with sufficient intelligence to give any assurance that they would be able to protect the defective daughter or sister, and none were closely supervised.

"There were 48 females with a history of known sex immorality after discharge, including 16 married women, 11 unmarried mothers, and 14 subsequently committed to other institutions. Five girls were promptly returned to the school because of immorality. Three women were known to be occasional prostitutes for hire before commitment to other institutions. Three women were known to have syphilis, all in the married group. We did not find any record of other venereal disease. Apparently the discharged female patients have not con-

tributed largely to the sex and venereal problem. Patients with active sex proclivities or with unsuitable relatives were not willingly discharged. The discharged cases had received years of habit training and education, and the relatives themselves had come to realize the possible sex proclivities of the patients. Apparently the women who had friends capable of understanding them, and of properly protecting them, did not have illegitimate children and did not become sex offenders.

"Twenty-nine women drifted into other institutions after discharge—4 to hospitals for epileptics, 10 to hospitals for the insane, 1 to prison, and 3 to girls' reformatories. In twenty-five years only 4 out of 176 women had been sentenced to penal institutions.

"As to the economic status of the 176 women, aside from the 11 successfully married women, only 8 were fully and independently supporting and maintaining themselves in the way of getting their own jobs and paying their own bills as ordinary working women do. Of these 8, 1 was earning $6 per week as a nurse maid, and had been four years in the position; 1 was earning from $3 to $7 per week, and had been out fifteen years; 1 received $4 per week in a candy factory, another $5 per week in a candy factory, 1 $9 in a cotton mill, and another $20 per month living in housework. All of them were morons.

"There were 32 helping with the housework and not being a burden, although not earning regular wages away from home, but capable of doing ordinary housework at home or for neighbors; some earning wages, but not a living wage, carrying a share of the burden of the home. One was in the illegitimacy group and had 2 illegitimate children, 3 had active sex tendencies, and 8 were disobedient and troublesome, but 20 had splendid records, and there was no reason why they should not continue to live at home. They were of the low-moron and high-imbecile group as a rule. These cases had friends able and willing to protect and care for them.

"There were 23 cases of the imbecile and idiot-group grade at home, not capable of self-support or of doing anything but the most simple housework; 2 were unmarried mothers; 2 were troublesome sexually; 6 were noisy and troublesome; but the others seemed to be well cared for and protected by their relatives, without annoyance to the neighbors or the family. The character of the home and the intelligence of the family largely determined the result.

"To sum up, for 176 discharged female patients, we have the following report:

Married (11 doing well)	27
Self-supporting and self-controlling unmarried	8
Working at home under supervision	32
Living at home, not able to do much work	23
Committed to other institutions	29
Died	24
Re-admitted to Waverley	33
Total	176

"Of the 90 discharged females now at liberty, 52 are apparently giving no trouble, viz:

Married, living at home	11
Self-supporting	8
Of those working at home	20
Of those living at home	13

"In the following tables, some persons are counted in more than one classification, so the totals apparently do not check—viz: some of the unmarried mothers are in the immoral group, illegitimacy cases in the re-admitted group, etc. The following groups have behaved badly, viz:

Married women, sex offenses	16
Unmarried mothers	11
Sex offenders not included above	21
Sent to other institutions	29
Of those working at home	12
Of those living at home	10
Re-admitted to Waverley	33

"Of the 470 males, 28 were earning a good living without supervision. All of these were morons. Their stay in the school had varied from one month to twenty years. They had been away from the school from two to twenty-three years. Eight ran away from the school. Others went on trial because they seemed useful and harmless, and were very desirous of their liberty. Few seemed capable of self-support while at the school. Their weekly wages ran from $8 to $36. They were working as teamster, elevator man, city laborer, factory worker, farm laborer, soda clerk, tinsmith, carpenter, painter, chauffeur, machinist, etc. One is in business for himself as a sign-painter, a trade he learned at the school. In fact, many are following occupations they learned at the school. One had saved $2,000; another had bought a house. Eleven of the group had married, and of these marriages there were 9 children. These 28 men seemed to

have a blameless record in their community. They are good citizens, regarded as simple-minded men and recognized as such by their employers, and by their wives, for where they had married normal women (as they nearly all did), the wives spoke very kindly of the mental limitations of their husbands.

"Thirteen men in all had married. As before stated, 11 were well behaved and industrious. Two married men were able to support themselves, but had been sentenced to the reformatory for larceny. There were 12 children altogether—6 had no children, 1 had 3 children, 3 had 2 each, and 3 had 1 each. The investigator saw all the children, and none of them seemed abnormal. The children were clean and well-behaved, and the homes were neat and well-kept. The two men with a criminal record earned $1.50 a day; the other 11 earned from $12 to $18 per week.

"Eighty-six were steadily working for regular wages, living at home, closely supervised by their relatives. Nearly every one was a moron, although there were a few high imbeciles. A few were receiving as low as $3 or $4 per week, but the majority received from $7 to $16 weekly. The average wage was $9.60 per week. They were employed in 39 different occupations, 13 in factories, painter, baker, laborer, printing pressman, freight handler, railroad brakeman, machinist, barber, etc. Only a few were doing simple manual labor. None of these boys or men had been troublesome sexually or shown criminal tendencies. They seemed contented and happy. These cases had been away from the school for an average of nine years. They were at the school for varying periods. In no case would the relatives consider a return to the institution, although nearly all expressed gratitude for the training received there. This group shows the influence of a good home in modifying the after-life of institutionally trained defectives without innate character defects. The good home presupposes the absence of hereditary criminal or antisocial tendencies.

"A group of 77 males of low-moron and high-imbecile grade and of various ages were able to do more or less work at home, but received no wages. Some were quite young, and have much of their lives yet to be lived out. Eight were attending public school, not keeping up, but learning a little slowly. These persons all seemed to be harmless and inoffensive. No record of sex offense could be ascertained. The males of this degree of mentality who had proved troublesome at home had evidently been returned to the institution. Where the members of this group lived on a farm or in a small village, they were evidently happier and did better in every way than those who lived in the cities. In this group also the lack of serious character defect and the fact that they were closely supervised were important factors in their good behavior.

"Fifty-nine males of idiot and imbecile grade, unable to do any work, were living at home, and the families seemed able and desirous of continuing the home care of the permanently infantile offspring. No serious obnoxiousness was reported by the families or by the neighbors or by the police. As in the preceding group, evidently those of the group who had proved troublesome had already been sent back to the institution. Favorable home conditions and the absence of disagreeable traits in the patients made home care possible.

"Thirty-two males are known to have been committed to penal or reformatory institutions subsequent to their discharge. Of this number 22 adult morons and 2 adult imbeciles were sent to penal institutions. Their average stay at the school was less than one year. Eleven ran away from the school, 9 were taken away by parents and 4 were discharged as unsuitable for the institution. Without exception, they were voluble, plausible, incorrigible, and apparently inherently crininalistic from early childhood. The crimes for which they were sentenced were as follows, viz.: 12 for larceny, 2 each for alcoholism, assault, and burglary, and 1 each for homicide, lewdness, sodomy, criminal assault, vagrancy, and highway robbery. Eight young boys were committed to juvenile reformatories for various offenses.

"Twenty-three males had been arrested for crimes or misdemeanors, but had not been sentenced to penal institutions. Of this number 16 were morons and 7 imbeciles. One of them had been at the school for ten years, 5 for four years each, and the rest for short periods only. Two ran away and the others were taken away by their parents. They were arrested for the following offenses—viz.: 5 for larceny, 5 for breaking and entering, 3 for drunkenness, 2 each for felonious assault, danger to young girls, assault and battery, and sodomy, and 1 each for setting fires and incorrigibility. This group also showed distinct character defects from early childhood, and, as well as the preceding group, should never have been released except under strict parole. Both groups were typical "defective delinquents," and could not be adequately cared for or restrained in a school for the feebleminded.

"Seventy-five of the males were committed to other institutions after their discharge, viz.: 8 to juvenile reformatories, 24 to penal institutions, 26 to hospitals for the insane, 8 to hospitals for epileptics, 4 to schools for the feebleminded, and 5 to various institutions. Few of these persons were discharged without a protest and often a contest. Many were taken away because of proposed transfer to the very institution to which they were eventually sent. Nearly every one was incorrigible and troublesome at home. This group well illustrates the necessity of frequent reclassification of the wards of the

state. This clearing-house function should be exercised in the institutions and not in the community.

"Sixty-eight males were re-admitted to the school. The time at home varied from less than one month to eighteen years. Seven were idiots, 42 were imbeciles, and 19 were morons. None of these cases had been arrested or in serious trouble, but they did not get on well, or were a burden at home, or were not easily controlled.

"Fifty-four died after they were discharged.

"To sum up, for 470 discharged male patients we have the following report:

Earning a living without supervision	28
Working for wages, supervised at home	86
Working at home, no wages	77
Living at home, not able to work	59
Arrested, but not sentenced	23
Sentenced to penal institutions	32
Committed to other institutions	43
Re-admitted to Waverley	68
Died	54
Total	470

"Apparently the cases represented in the first four groups in the above table—a total of 250—constituted no serious menace to the community at the time of the investigation.

"The results of this survey should be interpreted with great caution. As a rule, the most promising cases are allowed to go home. They have received careful training. The parents have been properly instructed. Still, many unpromising cases did well. There was a surprisingly small amount of criminality and sex offense, and especially of illegitimacy. We may hope for a much better record when we have extra-institutional visitation and supervision of all discharged cases. Those with definite character defects, especially those with bad homes, should be discharged with great caution. The survey shows that there are bad defectives and good defectives. It also shows that even some apparently bad do 'settle down.' And it shows much justice in the plea of the well-behaved adult defective to be given a 'trial outside,' for apparently a few defectives do not need or deserve lifelong segregation. It is most important that the limited facilities for segregation should be used for the many who can be protected in no other way."

THE RELATION OF DEFECTIVE MENTAL AND NERVOUS STATES TO MILITARY EFFICIENCY. By Karl M. Bowman, A.B.M.P. The Wellcome Second Prize Essay, 1919. *The Military Surgeon,* 46:651-669, June, 1920.

The military problem presented by defective mental and nervous states was brought to the fore in striking fashion during the war through the high percentage of rejections from the draft because of these conditions and the large number of cases that called for treatment in the army. Since, in the author's opinion, by no means all mental and nervous defectives are unfit for military service, the problem as he sees it is to determine in the first place what types are totally unfit, what types are capable of full and efficient service, and what types capable of limited service, and in the second place what can be done to keep the defectives who are in the army from breaking down, what are the best methods of treating such breakdowns as do occur, and, finally, what prophylactic measures can be taken to prevent the occurrence in the general population of such a high percentage of persons unfit for military service.

Under the term "defective mental and nervous states" the author includes all defects of the intellectual or emotional spheres, whether congenital or acquired. The most important of these he gives as follows: (1) mental deficiency, including all forms of feeblemindedness, (2) psychoses, (3) psychoneuroses, (4) organic nervous conditions, (5) constitutional psychopathic inferiority, (6) malingerers and conscientious objectors. Taking up each of these conditions, he discusses it in its relation to military service, illustrating with case histories. He subdivides the psychoses into (1) psychoses with organic disease of the nervous system, including "traumatic, senile, arteriosclerotic, and syphilitic psychoses, general paresis, Huntington's chorea, brain tumors, multiple sclerosis, paralysis agitans, epilepsy, etc.;" (2) psychoses with somatic disease, including drug and metal poisoning, pellagra, infectious diseases, post-infectious psychoses, exhaustive deliriums, cardio-renal disease, and disease of the ductless glands; (3) alcoholic psychoses; (4) manic-depressive psychoses; (5) involutional melancholia; (6) dementia praecox; (7) paranoia and paranoid states. The psychoneuroses include the large class of so-called war neuroses or "shell shock" cases, of which the principal types are hysteria, psychasthenia, neurasthenia, and anxiety neuroses. The group of organic nervous conditions consists of such conditions as epilepsy, chorea, internal glandular disorders, etc. Under "constitutional psychopathic inferiority" are classed "all those individuals who are, on a constitutional basis, unable to make the normal adaptation to life," the most important types being drug habitués, inadequate personalities, the

emotionally unstable, sex perverts, pathological liars, and criminals. This last group are unfit for any branch of the service.

The author summarizes his conclusions as follows:

"There are in the United States a large number of cases of mental or nervous disease or defect. This is shown by the fact that, out of every twenty men rejected in the draft, one man was rejected for mental defect and one man for mental or nervous disease. During the war every army had large numbers of cases of mental or nervous disease which markedly impaired the efficiency of the fighting forces. To secure the most efficient army possible, it is necessary to eliminate the mentally unfit as soon as possible, but to use available cases of mental or nervous diseases or defect whenever possible and where best fitted.

"To eliminate the mental defectives, the best way is to use the group examinations given by the psychologists to recruits. Such an estimate was perfected and used in our own army and is satisfactory. Border-line cases, depending on their mental age, their physique, and disposition, may be fitted for service. The vast majority of cases with a history of a psychosis are unfit for military service. Those offering the best prognoses are manic-depressive and infective exhaustive psychoses; acute alcoholic conditions, per se, are not a bar to service; chronic alcoholic conditions, if pronounced or with paranoidal tendencies, are. Especially should it be guarded against allowing arrested cases of dementia praecox and paranoia from entering the service. Every case must be judged on its individual merits and by a trained board of psychiatrists.

"Of the psychoneuroses, all extreme cases are unfit for service. Psychasthenia and anxiety neuroses are the worst types; hysteria and neurasthenia are the best. Because of the high intelligence of many psychoneurotics, they are valuable individuals and should be used, preferably in noncombatant service.

"The conscientious objector and the malingerer are frequently cases of mental disease, and, if so, should be treated as such; if not, they should be rigidly dealt with.

"To prevent nervous and mental diseases from occurring, the method used by our army in France is to be commended, and the method of treatment used is as good as has been devised. The public should be educated towards a truer understanding of the war neuroses in an endeavor to prevent their occurrence. In the future our army will be benefited in mental health and efficiency if the general education in the country is raised and English is universally known; if a program of general mental hygiene for the country is adopted; if syphilis is prevented and properly treated; and if a system of universal military service is adopted."

BOOK REVIEWS

Shell Shock and Other Neuropsychiatric Problems. Presented in Five Hundred and Eighty-Nine Case Histories from the War Literature, 1914–1918. By E. E. Southard, M.D., Sc.D., with a Bibliography by Norman Fenton, S.B., A.M., and an Introduction by Charles K. Mills, M.D., LL.D., Emeritus Professor of Neurology, University of Pennsylvania. Boston: W. M. Leonard, 1919. 982 p.

For several years Southard had been devoting some thought to the technique of writing a medical book. This, his last volume, may be said to be the final result of his thought on the subject. All things considered, it may be said to be a very successful effort to present a very complex subject. It combines a digest of the subject with a monograph of 37 pages of what he calls the epucrisis, or, to place it in more simple language, his conclusions.

Some 589 cases are presented in group forms, and for any one who takes the trouble to read them through, keeping in mind the groups, these cases force their own conclusions.

The title of the book is somewhat misleading—one might gather from the title page that it dealt solely with functional conditions. This is true only in so far as organic or psychotic conditions at times are complicated by functional conditions. If we take the case grouping, this becomes evident. These groups are as follows: (1) the syphilopsychoses, (2) hypophrenoses, (3) epileptoses, (4) pharmacopsychoses (alcohol-drug), (5) encephalopsychoses, (6) somatopsychoses, (7) senile and presenile states, (8) the manic-depressive group, (9) the psychoneuroses.

Two hundred and sixty-two pages are devoted to the above groups. Some 250 pages are devoted to war neurosis or to "shell-shock" cases. The rest of the 828 pages assigned to diagnosis and treatment are presented in the form of case records. All of these cases are concisely stated, with a legend carefully worked out to state the essential nature of the case presented in a very few words.

Southard's conclusions give the most accurate survey of the subject of "shell shock" (the psychoneuroses) presented up to the present time. It is a sane, scientific presentation of the subject by one qualified as a neuropathologist, internist, psychologist, and trained psychiatrist. No less than such a multiple expert could have brought such a survey of the literature to a successful conclusion.

The reviewer, with five years of experience in the field, in the front

line, in neurological hospitals, in hospitals at the base, and in convalescent homes, finds nothing in this presentation to criticize. While here and there there is evidence that the author had had little field experience, the results, notwithstanding this, are little less than remarkable.

The confusion in this subject was always due to faulty diagnosis and faulty medicine. One may say that there was nothing new, even in the first year of the war, that should lead an expert neuropsychiatrist astray in the field of war psychiatry. With Southard's conclusions (p. 871) "to regard the shell-shock neuroses as essentially dynamopathic, i. e. functional, whether in the ordinary mind-born (psychogenic) sense of classical hysteria, or in the modern nerve-born (neurogenic) sense of Babinski," and to consider "all other conditions as matters for careful and painstaking neurologic or general diagnosis," every real diagnostician will, I think, fairly agree.

A book review cannot do full justice to this masterly survey of the psychiatric material of the war. Every student of neurology, of psychiatry, of internal medicine—every one who has written a book or purposes writing a book in the field of medicine—should not only read, but read carefully and digest, every one of the 900 pages of this book. To the specialist in nervous and mental diseases, few books in this generation have been published which are as stimulating to new thoughts on a "decadent subject" as this. In addition, it is a new type of reference book.

To the medical author, accustomed to a stilted form of presentation, this offers a refreshing method of combined digest with conclusions colored by the experience and mature thought of the author.

One cannot leave the subject of the review of this, the last work of Dr. Southard, without a feeling of deep regret that such a man, with such a mind, should be lost to his profession just as he was approaching maturity. The field of medicine, even more than the special field of neuropsychiatry, needs the stimulating example that a continuation of such work, as presented in this volume, would have given.

D. I. McCarthy.

Man's Supreme Inheritance: Conscious Guidance and Control in Relation to Human Evolution in Civilization. By F. Matthias Alexander. New York: E. P. Dutton and Company, 1919. 354 p.

As the title would indicate and as the text boldly proclaims, the ambition of this author is to offer a panacea for social and individual ills. His argument is as follows: Instinct guides the coördinated

movements of lower forms of life. Man, on the other hand, has largely lost his instincts and has substituted in their place conscious guidance and control; in fact, this is the specialization of the human species. In adopting civilized life we have neglected to apply conscious control to our bodies. Hence depraved, degenerate instincts unconsciously guide our muscular functions. Ordinarily we perform simple acts clumsily, with ridiculous effort, using wrong muscles and working against ourselves. We do not even stand or walk properly. In particular we do not breathe as we should and, displacing vital organs, interfere with their normal functions and thus lay the foundation for or actually cause disease. By teaching conscious guidance and control of our bodies, Alexander claims to restore to health many debilitated, "neurasthenic" people. We do not doubt it. His argument up to this point is plausible—nay more, it is convincing. Any one who has tried to learn golf as an adult knows how wilfully his body refuses to perform apparently simple commands and is ready to believe that the same incoördination exists elsewhere, depleting his physical health just as it shortens his drive in golf. But unfortunately this is the introduction to, and not the conclusion of, Alexander's argument. He goes much further and, invading other fields of knowledge, comes to grief.

In the first place he makes incredible claims for the physical results of his treatment. One is ready to believe that any disease brought about by poor nutrition may benefit from the general improvement of the patient's physique, but specific and progressive disease cannot be eradicated by general means. When he tells us, therefore, that cancer may be cured by his principles and that in time they would eliminate all physical defects, we begin to wonder about his knowledge of simple medical facts or his judgment. These are not the isolated exaggerations of an enthusiast. He soberly begins a chapter with these words: "My first claim is that psycho-physical guidance by conscious control, when applied as a universal principle to 'living,' constitutes an unfailing preventive for diseases mental or physical, malformations, and loss of general efficiency."

In the second place Alexander makes an excursion into the field of mental hygiene. His argument is as follows: Individual unhappiness is largely, and social disease (including war) almost wholly, the result of improperly controlled instincts. This major premise he exploits to the full. It is not hard in these days, when "the unconscious" is heard at every turn, to establish such a thesis, yet probably half the book is given to its reiteration. Next comes his minor premise: Conscious guidance and control is learned by his system. The conclusion is inevitable. His system will reform the race by teaching mankind to control pernicious instinctive actions.

Naturally enough, anyone who is unfamiliar with psychopathological problems does not stop to ask exactly what kind of instincts or mental operations may be affected by his training, or to inquire if the ideas he teaches one to control are of the kind which produce severe individual or social disease. As a matter of fact, with many examples of reëducation of physical coördination and the dissipation of false ideas about the body—such as obtain in hypochondria—he gives not one single example of other, more abstract ideas being brought under control by his tuition *ad hoc*. A critical reader wades through many pages in which the above argument is repeated, hoping to learn how control of thoughts about the body may teach one to control reactions of the personality as a whole. It is only in an appendix that this information appears, one paragraph being devoted to the solution of the problem. Here one is told that control of the body serves as an object lesson. Nothing more. It is not difficult to understand Alexander's cures of some neurotics. The most normal of us are so because we inhibit the abnormal. In many neurotics the balance is but slightly upset; supply the patient with better physical health and encourage him to believe that he can control his symptoms and he may succeed. In other words, Alexander's treatment does all that restoration to normal physical health and suggestion can do, which, incidentally, is much. But this does not touch the problem of the pathology of severe nervous or mental disease, and to suggest that such means could ever control international rivalry is so grotesque a thought as to be tragic.

It is not hard to understand how Alexander has come to grief. Many and better trained scientists have been shipwrecked on the same rock. Physiology and psychology are two separate categories. That there are interrelations is true, that the boundaries are not accurately definable is also true, but this does not establish identity. No one can say just where fresh water becomes salt at the mouth of a river—in fact there is a shifting point where this takes place—but do we therefore confuse river and ocean? Both are water, just as physiology and psychology are both studies of life in general. A sufficiently simple-minded landsman might think that one who can steer a boat through rapids could navigate a liner from Liverpool to New York. Alexander is like one who has learned to run the rapids and so believes that he knows about the ocean, too, which is also made of water. Or we might compare him to one who, having devised a new and more efficient method of bricklaying, sets up as an architect. It might be difficult to teach a child of three years the difference between a bricklayer and an architect, and there is little doubt which vocation would seem more attractive to the infant

mind. Many people to-day write about psychology who know as little of it as a child and have a corresponding love of the concrete. Hence they confuse categories and try to make analogies into identities. We would recommend the reader interested in this important branch of logic as applying to the biological sciences to a little volume by Haldane entitled *Mechanism, Life and Personality.*

To the reviewer the recognition that this book has received is much more interesting than its subject matter. The American edition is introduced by as notable a philosopher as we have and a laudatory article has been written in a monthly magazine of wide influence by an equally noted sociologist. How is it that these men, trained in logic, have been so grossly deceived? The answer is simple —it is purely a matter of ignorance. Medical science has until recently neglected the study of the abnormal mind, so that charlatans have had more success in their treatment of nervous people than have regular practitioners. Consequently simple, fundamental facts have not been taught by the profession, which has been itself ignorant of them. On the other hand, the psychologists of America, with the exception of William James, have until recently taught psychology as a mixture of physiology and metaphysics, eliminating mental phenomena *as such* from their consideration. It is therefore not surprising to find intelligent laymen duped by specious arguments like those of Alexander. The need for sane propaganda in the sphere of mental hygiene is obvious.

JOHN T. MACCURDY.

EDUCATION IN WAR AND PEACE. By Stewart Paton, M.D. New York: Paul B. Hoeber, 1920. 106 p.

This little book of Dr. Paton's consists of three chapters: I. *Human Behavior in War and Peace,* which was the Harvey Lecture before the New York Academy of Medicine; II. *War and Education,* an address delivered at the Annual Meeting of the Head-masters' Association of the New England Schools; and III. *The Psychiatric Clinic and the Community,* an address delivered at the opening of the Henry Phipps Psychiatric Clinic, at Baltimore. They all deal with different aspects of the same problem—namely, the necessity for the study of man. In order that we should understand his ways of reacting, the author believes that we will not arrive at a solution of such vast problems as war, education, and social unrest until we understand man better. He takes his position squarely in line with the new psychology and, in the words of the historian Lecky, believes that "a study of predispositions is much more important than the study of arguments." He sees in psychiatry the particular discipline which has

appreciated this necessity and from it hopes much for the future. "The physician realizes probably to a greater degree than the members of any other profession that present social disorders as well as other diseases can be most effectively studied by beginning with the consideration of the facts in individual cases."

With regard to education, the author sees its great defects in that it does not prepare for the practical work of living; that it pays too much attention to the more highly developed, conscious processes and too little to the personality make-up; that it does not occupy itself sufficiently with questions of mental health; that it deals too much with the selection of subjects rather than with improving the methods of thinking; that it is essentially intellectualistic and does not give sufficient recognition to the feeling motives that lie behind; that it does not undertake seriously the work of assisting the student to realize his assets and liabilities and to regulate his life accordingly.

Dr. Paton sees in the new psychology, and the understanding that it will bring of man and his motives, the great hope of the future, and believes that through it may be accomplished the making of the world safe for democracy by making democracy safe for the world. His plea for a recognition of man as a feeling as well as a thinking animal he sets forth clearly and convincingly and in an illuminating way. The book is timely, suggestive, and sound, and its arguments need to be driven home in these days of unrest as the basis for a constructive policy and as an antidote to the thousand and one quack nostrums that are advocated as a result of the disintegration of the organized community of interests which we know as society. Dr. Paton is a clear and vigorous thinker; he speaks from conviction and has a message of value. The reviewer hopes that his book will be widely read, and, too, that he will continue to speak and that his voice may be widely heard.

William A. White.

Employment Psychology: The Application of Scientific Methods to the Selection, Training, and Grading of Employees. By Henry C. Link, Ph.D. New York: The Macmillan Company, 1919. 435 p.

Defining psychology as the application of the scientific method to the actions of the mind in general, the author defines employment psychology as the application of the scientific method to the mental actions concerned in employment. It is with the substitution of this application of scientific principles in the shop and in the office for the "hire and fire" method that this work is concerned.

The author insists (p. 19) that the psychologist must know the

job as well as the man in order to fit them together. A striking example of the necessity of studying the particular shop for which employees are being selected (p. 228) shows how the method of examination satisfactorily applied in the tool-making shop of one company, when carried over without adaptation to the tool-making shop of another company, failed to secure even an apprentice rating for two men who had previously given satisfaction in the latter shop. He insists upon the psychologists' going into the shop and learning the job as the preliminary for selecting the tests for that shop.

The method of procedure in general is: (1) a careful study of the work which the employee is expected to do; (2) subjection of the workers in that shop to psychological tests which seem applicable; and (3) correlation of the scores made by the individual employees with their own efficiencies as rated by output or by superiors. When such correlation has been obtained, the tests suitable for selecting workers for that shop stand out by their high correlations, and candidates for employment therein will be selected by the scores which they make from the same tests, standard performances having already been determined by the work of the employees.

The writer gives detailed explanations of the workings of these processes in applying employment psychology for the selection of employees as assemblers, inspectors, machine operators, tool makers, clerks, stenographers, and comptometers. The results obtained bear out his claim to the high value, both to the employer and to the employee, of psychology employed in the field of employment. Such an application of science clearly diminishes the labor turnover, and increases the efficiency and happiness of the worker. In a case of ninety-four inspectors (p. 51), who had terminated their services and who had been previously tested, it was found that the average term of service of those who had been recommended by the tests was 9.56 weeks, and the average term of those who had not been recommended by the tests was 1.05 weeks. It is seen, therefore, that inspectors selected by test worked nine times as long as those who were not recommended on the basis of tests.

These chapters, together with the appendix, furnish the methods for the use of the tests recommended. These parts of the book constitute a working guide for other employment psychologists.

A foreman is quoted as saying: "If we could find out beforehand whether a man would have the necessary speed after he has been trained to do the work, it would save us a good many very expensive trials." The author shows how this previous knowledge cannot be obtained by the time-honored methods of observation and conversation. The pseudo-science of character reading, by physiognomy or otherwise, cannot turn the trick; neither can conversation by those

most expert. Science is necessary; and he shows how in this shop work, just as in the army, the psychologist is able, by a half hour's work, to bring out facts concerning the character and ability of the applicant which it would require months of experience in a shop to obtain. For instance, a young woman, candidate for an office position, upon being interviewed by one of the office heads, was about to be turned down on account of her unprepossessing appearance (p. 83), but signs of intelligence led him to have her tested. She did remarkably well. She was hired, and in six weeks successfully mastered the routine of four different kinds of work.

The skeptical official comes in for reference (p. 98). This comptometry expert was asked to select twelve girls and to rate them by ranking them in the order of their efficiency. The same girls were given the psychological tests selected for comptometers and ranked according to their grades. The remarkable similarity of the rankings convinced the comptometer that the psychologist could find out, inside of an hour, what it had taken him weeks to ascertain concerning these girls.

There are useful chapters on Trade Tests, Vestibule Schools, and the Relation of Employment Psychology to Industry.

The book is not a straight-away procedure to a clearly conceived goal. The pathway over which the author leads the reader seems to be somewhat tangled. It does not give the impression that the whole matter was clearly outlined in the author's mind before he set out to write. There could have been no moment when the whole work existed together in the mind of the author as did a new-born symphony in the mind of Mozart. Organic unity, such as we demand in an æsthetic product, could not be expected in such a treatise, but there should be a steadiness of progress toward a clearly conceived goal. This is lacking. We must recognize, however, that the author is writing of a new field and make allowances therefor.

The book is a very useful presentation of the results of a careful and talented pioneer in the applications of psychology in the field of employment. It makes clear the serviceability of psychology for the purpose of selecting among applicants those who are best suited for the jobs in view. It makes clear the great superiority of the application of a real scientific method to the customary method of mere observation and interview.

THOMAS H. HAINES.

THE ALMOSTS. By Dr. Helen MacMurchy. Boston: Houghton Mifflin Company, 1920. 178 p.

With a fluent pen and a graceful narrative style Dr. MacMurchy gives us interesting vignettes of mental defectives described by

dramatists and writers of fiction from Shakespeare and Bunyan to our own contemporaries. We find mention of the ancient custom of English royalty of keeping fools or jesters, a custom that still subsisted in Scotland till late in the last century. The works mentioned are familiar to us all, and the reader is entertained to view again characters from familiar classics, such as Wamba in Scott's *Ivanhoe,* Dickens' Barnaby Rudge and Nicholas Nickelby, and Toots in *Dombey and Son,* about whom Mr. E. P. Whipple, in his introduction to that work remarks: "Owing to excessive cramming, Toots began, as soon as he had whiskers, to leave off having brains." Toots, however, was one of those permanent children who never grow up—a high-grade defective whose feeblemindedness did not become obvious until the time arrived for him to take on the responsibilities of adult life. Mention is made of Conrad's *The Idiots,* which is a dramatic portrayal of a couple, apparently normal, who meet the almost incredible tragedy of finding that all of their children are idiotic.

The author points to the fact that great writers discovered, long before the modern "uplifter" was born, that the mental defective must be reckoned with, "as one of those many things in heaven and earth that are not dealt with by some philosophers, and yet that make a great difference to the community and to social progress." Mental defectives cannot manage by themselves, though many of us have tried to pretend to the contrary, and often they are expected to learn what they cannot—urged, talked at, and often held up to ridicule, when it is not they, but the methods of modern teaching that are at fault; for they must be taught in the field in which we find them to be educable—generally speaking, in a world of things rather than in the field of education in the abstract—and should be given the childish pleasures and occupations necessary to keep them contented and occupied.

Thus, by means of the fictitious characters drawn by master hands so true to life that they are comparable with those we ourselves meet in the everyday world, the writer strives to unlock the great problem of the feebleminded that confronts us to-day—kindness, protection, and wise guidance being the keys that will keep these border-line cases from becoming a menace to society. As the mental defective should not marry and cannot make, or help to make, a home, the problem most pressing is to make happy and permanent homes for them during their lives. The only permanent parent, the author points out, is the state. The book is very readable, and underlying the text is the very serious motive of placing before us the great problem that concerns every state to-day.

L. Pierce Clark.

STATISTICAL DIRECTORY OF STATE INSTITUTIONS FOR THE DEFECTIVE, DEPENDENT, AND DELINQUENT CLASSES. Planned by Dr. H. H. Laughlin, Superintendent of the Eugenics Record Office, Cold Spring Harbor, New York, and tabulated and edited under the direction of Dr. Joseph A. Hill, assisted by Reginald L. Brown. Washington: Bureau of the Census, Department of Commerce, 1919. 256 p.

This valuable statistical review gives a census of inmates and financial statistics of state institutions for the following classes: (1) feebleminded; (2) insane; (3) criminalistic (including the delinquent and wayward); (4) epileptic; (5) inebriate (including drug habitués; (6) tuberculous (or others with chronic infectious segregated diseases); (7) blind; (8) deaf; (9) deformed; and (10) dependent.

The census was taken on January 1, 1916, and the data relative to total and per capita costs cover the year 1915. Information concerning the controlling body and executive officers of each institution was brought down to March 1, 1919.

In addition to the data relative to institutions, the volume contains an outline map of each state, showing the location of the several state institutions, and each map is accompanied by a table giving general statistics for the state and indicating its rank with respect to population, wealth, industries, literacy, etc.

Upon examining the volume, one is struck with the meagerness of the descriptive and explanatory matter. Less than one page is devoted to analysis and explanation, while the remaining 225 pages are given over to maps and tabular matter. The tables are well arranged for reference purposes, the maps are exceedingly well drawn, and the whole work gives evidence of much painstaking care. It is to be regretted, however, that no comparisons are made with data compiled from the records of the same institutions in previous years, and that no explanations of the results in the various states are given. It is also unfortunate that the work has lost much of its interest to the public on account of the delay in its publication caused by the entrance of the United States into the World War. There have been so many changes during the past five years that data relative to costs of maintenance and operation compiled in 1915 and 1916 have now very little value except by way of contrast. With the elaborate machinery of the United States Census Bureau, it ought to be possible to publish a volume of this kind within one year from the date of its inception.

HORATIO M. POLLOCK.

Introductory Psychology for Teachers. By Edward K. Strong, Jr. Baltimore: Warwick and York, 1920. 233 p.

This book attempts to develop a psychological attitude toward the teaching process by giving the prospective teacher first a problem of human behavior for solution and in the following lesson a discussion of this problem and its value from the viewpoint of the psychologist. Professor Strong's discussion starts with a consideration of behavior as a whole and gradually brings the student to such conventional topics as memory, attention, habit, etc. The course as given in the book is planned in such detail as to suggest the old-fashioned Sunday-school-lesson helps. Even the time for a mid-term examination is announced. The psychology of the text is of the orthodox, traditional type.

Ernest R. Groves.

Social Work. By Richard C. Cabot, M.D. Boston and New York: Houghton Mifflin Company, 1919. 188 p.

No one is more competent than the author of this book to formulate the general principles of social work and to stimulate the underlying motives—humanitarian, ethical, æsthetic, and religious—that are the essential basis of this movement.

The first half of the work is devoted to medical-social diagnosis, and the author gives in clear outline the main factors that are of importance in regard to the adequate study of the sick individual. It is always the patient himself who is in the foreground, and not merely his heart or lungs. The factors that influence the total efficiency and happiness of the individual patient, and the types of situation to which he may have to react and which may be contributing factors in the sickness, are admirably reviewed.

The chapters on social treatment are sober and well balanced. If much of this book presents what is no longer novel to those working in the field, it is largely owing to the author that the point of view has become so familiar, and there are many workers, both lay and medical, to whom a book of this type may be something of a revelation.

C. Macfie Campbell.

Military Psychiatry in Peace and War. By C. Stanford Read, M.D. London: H. K. Lewis and Company, Ltd., 1920. 168 p.

This small book by Dr. Read summarizes in a very agreeable way the psychology and psychiatry of the war as observed during his service at Netley Hospital, where practically all the psychoses were admitted. The opening chapter of the book describes the psychology

of the soldier as he is entering the service—his feelings of tension and anxiety; how these are relieved when he joins up with others and becomes part of the herd; how he reacts to the various fresh adaptations, through training and finally at the front, where he goes over the top. All this is described in a way that is of interest to both the lay and the medical reader. A summary is given of military psychiatry during peace, mainly in reference to statistics of the types of disorder found, much of this material being taken from American army records.

From what is included under *General Psychiatric Considerations in War,* one learns that the English physicians made a number of the same errors that were made in this country. Men were admitted to the service who never should have been received, because of psychoses or mental deficiency, and these patients were a very considerable drag on the rest of the army.

The writer feels that exhaustion in itself was not a prominent factor in the cause of psychoses, and is in accord with most observers that psychogenic causes are of the greatest importance. In the English army acute illness, both malaria and dysentery, were of considerable importance. A number of alcoholic cases were also seen, although the writer does not agree with some of the French writers who attribute many of the psychoses to alcoholism.

From August 1914 to May 1919, 12,320 cases went through D Block of Royal Victoria Hospital, Netley. These came not only from France, but from Mesopotamia, Egypt, Salonica, German East Africa, Italy, and British East Africa. The recovery rate was remarkably high, being about 52 per cent, with the exclusion of mental defectives.

The English have taken a very broad attitude on the question of pension in cases of mental diseases. For instance, syphilitics who developed paresis are entitled to pension; alcoholics who developed psychoses are entitled to pension if there are any complicating factors such as mental or physical exhaustion; epileptics who develop insanity are entitled to pension; and as a rule a man discharged from the army because of insanity is pensionable unless it is shown that he has had more than one attack of certified insanity before enlistment.

The clinical material, which Dr. Read gives in considerable detail, is very clearly presented. He describes the various psychoses and types that he encountered during this service. In interpreting these reactions, one would perhaps be inclined to lay more stress upon the actual situation and upon the unusual conditions of war as a causative factor than Dr. Read is inclined to do. For example, he has classified all except 2½ per cent of his cases under some one of the conventional headings.

In the American service it was felt that conditions were so unusual and the exciting factors of such a character that no acute cases, such as those showing paranoid states or acute hallucinatory conditions, should be classified under the conventional terms, implying thereby the usual prognosis.

Dr. Read has said, as most writers on the war psychoses have stated, that the war showed no new types of mental disorder. While one may agree with this in its broadest sense, one may also feel that the novel circumstances of the war brought about acute mental disorders in practically normal men; that these disorders were of transient character, having to do entirely with the situation in which the men found themselves; and that such states had very little in common with what one generally meets in civil life.

Dr. Read has encountered a large number of confusional states. These conditions were seen in the American Expeditionary Forces also. The clinical picture they presented was very puzzling. Sometimes a marked psychosis was associated with a serious neurosis such as paralysis, or tremors, or contractures. While it may be said that this is not an entirely new clinical picture, it is quite unusual, and the interpretation of these states along formal lines does not seem warranted. A lesson that we might gain from experience with the mental reactions of war would seem to be that in the past we have placed too much stress on what we considered inherent or innate tendencies of the individuality, and have given too little regard to environmental influences. The war would seem to demonstrate what may be brought about in the way of psychoses and neuroses under certain types of environment, and if in our civil-life observations more stress could be laid on the social setting in which maladjustments arise, considerable might be gained. This is a point of view that Dr. Read has touched upon very little in a book that in other respects is of real and permanent value in its relation to the psychoses of war.

Sanger Brown, II.

An Outline of Abnormal Psychology. By James Winfred Bridges. Columbus, Ohio: R. G. Adams, 1919. 126 p.

This book is a distinct contribution to the resources now available for students of psychiatry and mental hygiene and furnishes in compact form a brief description of abnormal mental phenomena, supplemented by a good bibliography on each subject. The author's foreword well expresses the object of the book:

"This outline presents a fairly complete list of the abnormal mental phenomena, it shows how these prenomena are grouped into the

syndromes manifested in the various psychoses and neuroses, and it summarizes briefly the most important etiological facts and explanatory theories of the mental anomalies and diseases. An attempt has been made to present in summary the various aspects of this many-sided subject without disproportionate emphasis or neglect of any topic or theory.

"The purpose of the outline is to serve as a guide for students of abnormal psychology in the absence of a comprehensive textbook. It is hoped that it will be found useful also by those medical students and students of social service who desire a general survey of this field, but who have insufficient time for a regular supervised course or for extensive reading of the very much scattered literature. It should of course be regarded as mainly directive and mnemonic; and the references should be consulted for illustration of facts and exposition of theories."

The book is conveniently divided into three parts. Part I is devoted to a description of the abnormal phenomena of sensation, perception, consciousness and attention, memory, association or thought sequence, judgment or the validity of thought and belief, orientation, feeling and temperament, instinct and emotion. Under the last named subjects the author includes fear and the sexual instinct. In his classification of instincts he follows McDougal. In explanation of fear he gives the various theories of Freud, Prince, and Sidis. He also considers innate action and its mechanism, and acquired action or habit and conduct, under which he describes apraxia, speech and writing, inhibition and impulsion, will and character. The current methods of measuring intelligence are shown, including those used by Terman and Healy, and the point scale as introduced by Yerkes and the author himself. A description of the abnormalities of personality and the theories of sleep, dreams, and hypnosis concludes the first part.

Part II gives brief descriptions of the mental syndromes or symptom complexes of insanity. The many theories advanced concerning the psychoses include, among others, those of Kraft-Ebing, Kraepelin, Bleuler, Freud, and Adler, while many American authors, such as Meyer, Southard, Prince, White, and Hoch, are quoted.

An outline of the border-line diseases, the psychoneuroses, and the epilepsies constitutes Part III and includes chapters on neurasthenia and the anxiety neurosis, hysteria, psychasthenia, and epilepsy; in the last chapter the theories and classifications of the neuroses in general are given according to Freud, Jung, Adler, Sidis, and Kraepelin.

The bibliography is satisfyingly concise, but complete. One would like to see included, however, such a standby as Bleuler's *Dementia Praecox*, and one wishes, too, in order that the book might be of the

greatest possible value to those for whom it is intended, that the author had also added, in the study of personality, the consideration of characterologic traits, such as are described by Hoch, Amsden, and others.

The book will be welcomed as filling a great need among students of psychiatry as well as among students of social work who at the present time are struggling with the various theories of mental disease and abnormality that may seem to them both confusing and contradictory.

The author is to be congratulated on his clear exposition of these opinions and their good arrangement in this well-ordered handbook. The method of using a psychological classification as the basis of classification for abnormal mental symptoms is particularly helpful. Perhaps the book's greatest value lies in the fact that the subject matter and the bibliographies include both psychological and psychiatric material, making it equally valuable to students of psychology and of psychiatry.

EDITH R. SPAULDING.

REVIEW OF APHASIA AND ASSOCIATED SPEECH PROBLEMS. By Michael Osnato, M.D. New York: Paul B. Hoeber, 1920. 183 p.

This book is a technical discussion of the problems of speech viewed from the neurological standpoint. It is valuable for the neurologist and psychologist, but without much meaning to the laymen in these fields.

It deals largely with the traditional concept of the localization of speech in the so-called Broca's convolution. Osnato follows Marie and his scholar Moutier in denying that there is good evidence for such localization. He believes with these and other writers that, while speech defects occur as a result of injury to the brain, that injury involves many functions, including the intelligence.

A. MYERSON.

RECONSTRUCTION THERAPY. By William Rush Dunton, Jr., M.D. Philadelphia: W. B. Saunders Company, 1919. 236 p.

The title of Dr. Dunton's second book dealing with occupational therapy is very broad, due, doubtless, to the fact that the text was completed during the war period. Therefore it was natural that military-hospital problems and the terminology used during that period should have determined the title of the book. A continued use of the descriptive term might eventually bring about a higher regard for the work now installed in many hospitals under the division of occupational therapy—all so ably described by Dr. Dunton.

One of the strong features of the book and one that makes it of great immediate value to occupational therapists and to others interested in the work is the complete bibliography contained therein, showing the hours spent in research along this particular line. It is so complete that one might suspect this form of occupation to be Dr. Dunton's hobby, recommended in his credo.

The suggestive scheme of organization is excellent, but each hospital presents an individual problem so far as organization is concerned, unless it be state or municipal hospitals, and these are governed by local laws and conditions. With a new division of service, it is important that the worker fit in the work with any scheme of organization that makes a place for it, and that there should be a staff of teachers without too firmly a preconceived notion of how things must be.

If Dr. Dunton is good enough to offer another edition of this valuable book, it would seem important to outline what equipment and materials are necessary to start work, in minor crafts for instance, with groups of varying sizes—say thirty, fifty, or seventy-five; how equipment should be divided between curative workshops and ward work; the best methods of application to both mental and physical cases; and the therapeutic results to be looked for by the occupational therapist and to be expected by the physician.

The book is most heartily endorsed for workers and students in occupational therapy. There is an insistent demand for a textbook giving an analysis of technical steps that will lead directly from bedside occupations to industrial pursuits, with proper emphasis upon the improvement in morale and the far-reaching psychic elements involved in the final stages of the patient's progress.

The fine distinctions drawn between vocational training and occupational therapy are important to every student and teacher because they present the opinion and viewpoint of a medical man who has worked out craft steps with patients and who makes plain the fact that progressive processes, constructive in character, benefit both mind and body. In many cases the occupation teacher can better prepare the patient for vocational reëducation (p. 118) than the technician, who has not so comprehensive a view of the subject as the teacher. It is a matter of regret that the illustrative material does not include pictures of shops, ward classes, special case work, etc., now being conducted in various parts of the country.

Eleanor Clarke Slagle.

COURTS IN THE UNITED STATES HEARING CHILDREN'S CASES: RESULTS OF A QUESTIONNAIRE STUDY COVERING THE YEAR 1918. By Evelina Belden. Children's Bureau, United States Department of Labor, Publication Number 65. 115 p.

The facts presented in this report relate, in general, to the year 1918, during the spring and summer of which replies were received to questionnaires sent out to all the courts in the United States that hear children's cases. The method by which the study was conducted was through questionnaires and correspondence. Information was sought from every court that had authority to hear children's cases involving delinquency or neglect.

Two thousand, three hundred, and ninety-one courts were addressed, 85 per cent of which replied to the questionnaires sent out. One thousand, two hundred, and sixty-nine courts reported a total of 140,252 cases heard. It is probable that the number of children's cases that annually come before the courts in the United States approximates 175,000.

Ninety per cent of the courts addressed served communities in which there was no city of 25,000 or more inhabitants. The importance of the problem of court organization for small towns and rural communities is evident.

The report groups courts under two main heads—specially organized courts and courts not specially organized, so far as known. Only courts reporting (a) separate hearings for children's cases, (b) specially authorized probation service, and (c) the recording of social information were classified as specially organized. The minimum degree of specialization defined above was reported for 321 courts. Of these 321 courts, 22 were juvenile courts established by special laws and independent of other court systems.

All the courts from which replies were received serving cities of 100,000 or more inhabitants were specially organized, while 71 per cent of the courts that served areas containing medium-sized cities were specially organized. Sixteen per cent of the courts serving small cities and 4 per cent of the courts serving only rural areas were specially organized.

The majority of the courts which heard children's cases reported separate hearings for juveniles. A considerable number of the smaller courts, however, reported that hearings were not separate.

Many courts reported that a woman was present at the hearing for girls. She was, in most instances, a probation officer. In 6 large cities, specially qualified women served as referees for girls' cases. In one city—Washington, D. C.—the judge of the juvenile court is a

woman; and in 7 counties of Kansas, probate judges who also heard children's cases were women.

Thirty-seven courts in 18 states reported that no effort was made to separate children detained in jail from adult offenders, though in many of these states such separation is required by law.

A total of 212 detention homes or rooms in 38 states and the District of Columbia were reported. A considerable number of courts used as a method of detention the boarding of children in family homes, or placing them in the custody of court officials. This is quite common in Massachusetts.

Every state in the Union except one had legislation providing for juvenile probation, though less than one-half the courts having jurisdiction over children's cases—45 per cent—were known to have had probation service. All the courts serving cities with a population of 100,000 or more had probation service; 94 per cent of the courts serving areas containing medium-sized cities had probation service, and 66 per cent of the courts serving areas containing small cities, while only 25 per cent of the courts serving rural areas reported such service. In only 8 states was a recognized worker for every court reported. Less than one-half of the courts reporting probation work had regular officers giving full-time service and paid for by the court. In 6 states agencies were reported which were supervising juvenile probation work throughout their respective states, thus tending to standardize the work of the various courts. These states were Massachusetts, New York, Connecticut, Rhode Island, Vermont, and Utah. In 8 other states the courts were responsible in a limited way to the state board of charities or to some similar body.

Six hundred and seventy-one courts reported provisions for physical examination. In 23 courts, of which 21 were special courts serving large cities, physical examinations were made by physicians attached to the staff of the court, regularly making these examinations for the court.

One hundred and forty-five—or 7 per cent—of the courts addressed reported mental examination in clinics organized for the purpose, or by persons having some psychiatric or psychological knowledge. Those courts having special provision for mental examination often examined only cases presenting special problems, or repeaters. In only 13 courts were there clinics maintained as a part of the court organization where examinations were made by psychiatrists or psychologists definitely attached to the court. In two states—Illinois and Ohio—departments had been established by law for the mental diagnosis of children brought to them from the courts of the state.

"Among the courts included in this study may be found illustra-

tions of all stages of development away from the old and toward the new ideals and methods. Many courts had arranged for separate hearings for children's cases, but still maintained the old attitude and imposed the old punishments. Lack of an adequate probation service, the absence of any method of detention other than the jail, failure to secure adequate social information and to provide a method for recording and utilizing these facts, judges who were not well qualified for their work and who failed to grasp its fundamental principles, unnecessary publicity of hearings—one or more of these and other defects in organization were frequently found."

"It was estimated that 175,000 children's cases were brought before the courts in 1918. Of these approximately 50,000 came before the courts not adapted to the handling of children's cases. Statistics cannot adequately reveal the injury done these children through their association with adult offenders, their trial under the old criminal processes, and the absence of equipment for the study of their needs or for proper oversight and protection."

The report deals with the significant tendencies in juvenile-court work in this country, and calls attention to the wisdom of dealing with the child offender not as a wrong-doer, but as one in special need of care and protection. In the words of a former juvenile-court judge, "The problem for the court is not fundamentally to decide whether or not the child has committed a specific wrong, but what is he, how has he become what he is, and what would best be done in his interest and in the interest of the state to save him from a downward career."

The report states that the problem for the immediate future is the working out of practical methods by which the principles of the juvenile court may be universally applied. It very wisely emphasizes the importance of knowledge of the child's physical and mental condition, of his home and family and personal history. Mention is made of the recent development in connection with coördinating juvenile courts and domestic-relations courts into one family court, such court to include desertion and non-support cases contributing to delinquency and dependency, divorce, illegitimacy cases, adoption, and guardianship.

The chapter on *Fundamental Principles* concludes with the following statement:

"As the work of the juvenile court develops, some of the underlying causes and conditions of child delinquency and neglect become more evident. The results of intensive studies of individual children have indicated the varieties of provision which must be made. The need for the early recognition and treatment of abnormalities in the child's physical, mental, or moral development has been conclusively

demonstrated. In this field the responsibility reverts to the home, the school, and the other social forces of the community. The adequate fulfillment of these obligations will result in the prevention of a considerable amount of juvenile delinquency and in the consequent reduction of the number of children who come before the courts."

V. V. Anderson.

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NOTES AND COMMENTS

Connecticut

A new reception building will be opened in the near future at the Norwich State Hospital. This building will accommodate 100 patients, 50 of each sex. It will have a modern hydrotherapeutic department, including the latest approved type of electric and steam baths. The building with its equipment will cost about $250,000.

Florida

As a consequence of the report of the committee appointed in 1915 to investigate the needs of a state institution for the care of feebleminded and epileptic, the legislature last year enacted a law establishing the Florida Farm Colony for Epileptic and Feebleminded (Chapter 7887, Laws of 1919). The purposes of this institution are outlined as follows: it is to be used (1) as an asylum for the care and protection of the epileptic and feebleminded; (2) as a school for the education and training of the epileptic and feebleminded; and (3) as a colony for the segregation and employment of the epileptic and feebleminded.

The institution is to be located near Gainesville on a 3,000 acre tract, and construction will soon be begun. The first building to be erected will have 120 white female patients and will contain administration offices. Quarters for the superintendent and his assistants will be built next. It is planned to enlarge the institution from year to year and eventually to take care of all the feebleminded and epileptics now at the state hospital as well as those received from the community. Preference in admission is to be given to women of child-bearing age. The sum of $50,000 was appropriated for 1919 and $100,000 for 1920.

By legislative enactment the name of the Florida Hospital for the Insane has been changed to the Florida State Hospital.

Georgia

The state institution for feebleminded, which was authorized by the 1919 legislature, is located at Augusta, on the site of the Tuttle-Newton Home for Orphans. This is a cottage institution with a central administration building and four or five cottages with a total capacity of about 120. The buildings are of fire-proof construction and the land comprises 325 acres.

The Lenwood Hotel, at Augusta, is being converted into a government psychopathic hospital for soldiers from the states south of the Mason-Dixon line and east of the Mississippi River.

Louisiana

House Bill 313, now before the Louisiana legislature, is to amend and reënact certain sections of Act 141 of the Laws of 1918. This act, which created a colony and training school for mental defectives, was briefly summarized in the last number of MENTAL HYGIENE. The new provisions deal principally with the question of the payment of the fee for the physicians and psychologists selected to make the examinations and reports on the mental condition of the alleged feebleminded persons, and the expenses incurred for the detention, treatment, and conveyance of feebleminded persons to the State Colony and Training School. Another new provision makes it necessary that the answers to the interrogatories prescribed by the board of administrators of the school must be made and sworn to in duplicate, one copy to be filed with the records of the case by the clerk of the court, and the other to be taken with the feebleminded person to the state school.

Another bill that has been introduced in the Louisiana legislature (House Bill 315) provides for admission without court procedure of feebleminded persons to the State Colony and Training School. Application for such admission may be made (1) by the father or mother, if they are living together; (2) by the one having custody of the child, if the parents are not living together; (3) by the guardian; (4) by the superintendent of the parish poor farm or other administrative officer in charge of a children's home or orphanage; (5) by the police jury of any parish. This application must be accompanied by full answers to all the questions presented by the board of administrators and by all information required by the board. Upon receipt of the application, the superintendent must make or have made a complete physical and mental examination of the person. If he is satisfied that the person is feebleminded and if accommodations are available, the person may be received into the institution. Any person thus admitted is subject to parole as provided for in the case of other inmates. Such person can be discharged only upon application to and proper orders from the district court of the parish from which he was admitted. Any feebleminded person thus admitted may at any time petition the court to discharge him from the institution, and when such petition is properly filed, the court shall proceed as provided in Section 18, Act 141, Laws of 1918. Discharges may be granted because

the person is not feebleminded, because he has so far improved as to be capable of caring for himself, or because the relatives or friends are able and willing to supervise, control, care for, and support him and request his discharge.

The present bill also provides for the transfer of patients to and from the state hospitals for mental diseases and the state institution for the feebleminded.

The parole provision is as follows: "Whenever, in the opinion of the superintendent of the State Colony and Training School, it would be to the advantage of any inmate of the institution, and to the advantage of the community, to parole such an inmate to a given private home, and after having had the proposed home and community investigated by an agent of the State Colony and Training School, he may grant such a parole to such patient for any length of time he deems advisable."

A person applying for parole of the inmate may be required by the superintendent to sign a written obligation to care properly for the inmate while on parole, and to return the patient to the colony at his own expense if the parole terminates or is revoked. Every inmate of the State Colony and Training School placed on parole must be visited frequently by agents of the institution, and reports must be made to the superintendent to assure him that such inmates are properly cared for. The superintendent has the power to recall a paroled inmate to the institution.

Maryland

A law enacted by the legislature of 1920 (Chapter 735) provides for the custody, pending trial, of persons alleged to be insane who are charged with crime and are unable to procure bail. This law stipulates that whenever any person is brought before a judge of any court or before any justice of the peace having criminal jurisdiction, and such person shall appear to be insane or be alleged to be insane, and shall be committed in default of bail, the judge may commit him to such institution for mental diseases as the Lunacy Commission may designate. Upon notification of such commitment, the Lunacy Commission shall examine the prisoner and within two weeks report its findings to the judge or justice then having jurisdiction of the charge against such person. Should the prisoner be insane, he is to remain in the institution to which he shall have been committed. If found sane by the Lunacy Commission, the court or justice shall order him transferred to the jail of the county or city in which such crime is pending. In all cases not punishable by death or confinement in the penitentiary, the examination may be made by the su-

perintendent of any institution for the care of mental diseases in which such person may be confined pending trial, and such superintendent shall within three weeks make his report in writing to the court or justice of the peace before whom such charge is pending, and further proceedings shall then be had as if such report had been made by the Lunacy Commission.

Also by this law, the Lunacy Commission may remove dangerous insane patients cared for at public expense and confined in any private, corporate, or state institution or asylum to such other state hospital as may be selected.

Any convict removed by the Lunacy Commission because of insanity or feeblemindedness from any penal institution to an institution for mental diseases to be designated in the order of removal, upon recovery from his mental condition shall be returned to the penal institution upon recommendation of the Lunacy Commission, there to be confined until the expiration of the term of sentence. If any convict, in the opinion of the commission, be still insane or feebleminded at the expiration of the term for which he was sentenced, he shall remain in the institution until he shall have recovered his reason.

By an act of the general assembly of 1920, $100,000 has been appropriated for the erection and construction of a building for insane persons with violent or criminal tendencies.

Chapter 206, Laws of 1920, authorizes the transfer by the Lunacy Commission of insane or feebleminded persons cared for at public expense in any institution in the state, who are residents of other states, to similar institutions in their own state, at the expense of this state, and also provides for the transfer to this state by other states of patients belonging to Maryland, who are being cared for in similar institutions outside of Maryland. This provision does not apply to persons who have been transferred to penal institutions whose sentences have not expired.

Michigan

By the terms of an act of the last legislature, the medical superintendent of each hospital for mental diseases may, with the approval of the board of trustees, establish in the district served by the institution clinics for the free examination of the mental condition of persons presenting themselves or being presented for examination.

Mississippi

A state institution for the feebleminded is created by Chapter 210, Laws of 1920, to be known as the Mississippi School and Colony for

the Feebleminded. The government of this institution is vested in a board of seven trustees appointed by the governor with the advice and consent of the senate. The superintendent is to be appointed by the board of trustees. He must be a graduate of a reputable medical college, and must have a wide experience in the care and training, education, and reëducation of mentally defective and mentally diseased persons. The institution will be located at Ellisville on a site comprising about 2,700 acres of land. There are about thirty dwellings on this land, so an early start of the institution is in prospect.

The institution is to be so arranged that provision may be made for the segregation of the white and colored and also of the sexes. There are to be separate cottages for epileptics, and others for criminal and immoral mental defectives.

The law states that "the institution shall provide for the training of all young persons to the fullest extent of which they are capable, and in a manner that shall best fit each for a life of usefulness. Training in the use of hands being considered of the highest importance, the educational activities of the institution shall be primarily directed toward perfecting the pupils in the arts of the farm, of the house, and of the shop."

Frequent mental examinations of every inmate must be made and a research department established to study the causes of mental deficiency with a view to prevention.

The following divisions are suggested for the data to be obtained and filed in the case of each child: physical examination, personal history, family history, school history, industrial history, civil and social relations, and mental development.

The law provides for the admission of minors without court commitment upon the application to the superintendent of the colony of father, mother, or guardian. This application must supply such information as the superintendent and board of trustees shall require. If, after examination, the superintendent finds the child to be feebleminded or epileptic, the child is admitted and then becomes a ward of the state. The child may be released by the board of trustees, by the superintendent, by order of a chancellor, or of a judge of the supreme court of the state, by due process of law.

Commitment to the colony by court procedure is provided for as follows, the chancery courts having jurisdiction in all cases of legal inquiry in regard to feeblemindedness:

"At any time, subject to the approval of the court, any relative of a feebleminded person, child, or adult, may make application to the clerk of the chancery court to have him adjudged feebleminded;

but if the relatives of any feebleminded person shall neglect or refuse to make application to the clerk of the chancery court to have him adjudged feebleminded, and shall permit him to go at large, the clerk of the chancery court shall, on the application, in writing and under oath, of a citizen of the county in question, issue a summon to the sheriff to summon the alleged feebleminded person and his parent, guardian, or next friend to contest the application.

"The application shall request that the alleged feebleminded person be adjudged feebleminded, and in need of proper care. It shall state the facts upon which the allegation of feeblemindedness is based, and because of which the application is made."

Two physicians selected by the court, or by the clerk of the court, as having the best available qualifications in the field of mental medicine, shall then make a thorough physical and mental examination of the person alleged to be feebleminded and investigate his personal and family history. They must make their report in the form of a certificate of their findings to the clerk or the judge of the court. The certificate is made in duplicate in accordance with an outline prescribed by the board of trustees of the Mississippi colony, both copies being sent with the person when he is committed to the institution. One copy is retained by the superintendent and the other returned with his signature, serving as an acknowledgment of the reception of the patient.

After the petition for commitment has been filed, and after the physicians have certified that in their judgment the person is feebleminded, the clerk issues a summons requiring the parents, or nearest of kin, or guardian to appear with the person at a stated time and place. The court may require other evidence in addition to the petition and certificate of the physicians, and may summon other witnesses. The alleged feebleminded person has the right to demand trial by jury, or the court may, on its own motion, call a jury to try the case. The hearing may also be held in private.

When any person charged with a crime or delinquency is brought before any conservator of the peace and appears in the course of the investigation to be feebleminded to such an extent as not to be responsible for his act, he shall be reported to the chancellor or clerk of the chancery court, who must proceed to commit him. This provision also applies to persons held in prison, or on bail, charged with an offense, and to persons indicted for an offense who are acquitted on the ground of feeblemindedness, if the person is in danger to the community or to himself.

The law provides for the transfer of feebleminded and insane patients between this institution and the hospitals for mental disease.

The superintendent may discharge any inmate who has not been charged with a felony, misdemeanor, or juvenile delinquency, when in his judgment, after careful and repeated examination, the inmate is not feebleminded and is able to manage himself and his affairs with prudence. If a patient has been charged with the offenses above stated, he can be discharged from the colony only upon the order of the court that committed him, or of the supreme court of the state The superintendent may also parole inmates to a private home if, in his opinion, it would be to the advantage of the inmate. The proposed home and community must be investigated by an agent of the colony, and the superintendent may require a person applying for the parole of an inmate to sign a written obligation, with sureties, to care properly for such inmate and to return inmate to the colony at his own expense in the event the parole terminates or is revoked. The superintendent must recall a paroled inmate whenever he is not satisfied that the welfare of the inmate or of the community is adequately provided for.

"Boards of supervisors, in their respective counties, shall temporarily provide for the maintenance of any person alleged to be feebleminded when such person has no means of paying such expense, pending an investigation into the mental status of such alleged feebleminded poor person before the chancery court of such county, provided that no feebleminded female shall be maintained at the county poor farm. All care of such feebleminded females must secure their protection and segregation. It shall be the first duty of boards of supervisors, in extending care and protection to feebleminded persons, to prevent the propagation of the feebleminded."

A bill that was before the 1920 legislature at the time of its adjournment, which will be introduced by the next session, is the "Mississippi Insanity Law." One of its sections would change the names of the two state hospitals by eliminating the word "insane." The bill would provide for the appointment by the board of trustees of a superintendent for a term of five years, who must be a graduate of a reputable medical college, must be of good moral character, and must have had experience and training in the diagnosis, treatment, and institutional care of mental diseases.

"The prime object of the hospital is the recovery of the mentally sick, and the prevention of nervous and mental diseases. The superintendent shall, therefore, organize and direct the work of the medical staff to the end of making the most accurate diagnoses possible, and securing for the patient, from day to day, the most effective treat-

ment, and rendering all possible community service in preventing disease."

The superintendent, under the direction of the board of trustees, shall appoint a medical director, who must be a trained psychiatrist. His duties are outlined as follows: "He shall organize the staff of physicians to secure the most careful examinations of patients, and the most speedy recoveries of as many as possible. He shall plan and oversee the making of records of all mental and other medical examinations and treatments. He shall organize and manage the laboratories and all examinational work done therein. He shall have charge of post-mortem examinations and pathological studies. He shall hold meetings of the staff twice a week, or as often as may be necessary, for the examination and diagnosis by the whole staff of every new patient, for the examination of patients to be paroled or discharged, and for the training of younger members of the staff. He shall be especially charged with the research work and the preventive work of the hospital. He shall stimulate and encourage research studies into the causes of nervous and mental diseases on the part of each member of the staff."

Commitment to the hospitals for mental diseases is provided for as follows: Any relative or friend of an alleged insane person or any citizen may have him brought before the chancery courts for a hearing on the question of his sanity. The court requires the certificate of two disinterested, qualified physicians who have thoroughly examined the alleged insane person at least ten days before the hearing. The hearing may be held in private or there may be trial by jury.

The following forms of commitment are also provided for:

1. *Emergency commitment* of not more than ten days for those violently or dangerously insane. The certificate of one citizen and two physicians is required. Within ten days the patient must be duly committed or removed.

2. *Temporary care* not to exceed ten days. Upon the request of a physician, a member of the board of health, a health officer, or a police officer, the superintendent may receive and care for as a patient any person needing care and treatment because of his mental condition. This provision applies only to those temporarily deranged, as alcoholics or drug addicts. If a person thus received is not removed at the end of ten days, or if he does not sign a request to remain as a voluntary patient, the superintendent must cause him to be duly committed according to law.

3. *Voluntary admission.* The superintendent of a state hospital may receive any person making a written application for treatment,

whose mental condition is such as to render him competent in the opinion of the superintendent to make such application. The superintendent must notify the chancery court of the county in which the patient resides immediately after he is received. The patient must not be detained more than ten days after having given written notice of his desire to leave the hospital.

The superintendent may discharge patients, except those held on court order on account of a criminal offense, at any time as follows: (1) a patient who in his judgment has recovered; (2) one who is a dotard, not insane; (3) one who has not recovered, but whose discharge will not be detrimental to the public welfare or to the patient.

Parole may be granted by the superintendent for a period not to exceed one year. Within this time a patient may be returned without a new order of commitment. When a patient has remained on parole one year, he shall be recorded as discharged.

Each state hospital shall organize a department for community service whose duties shall be (1) to supervise and assist patients who have left the institution; (2) to provide for informing and advising indigent persons, their relatives or friends, or charitable agencies as to the means of prevention and the treatment of mental conditions, and as to the available institutions or other means of caring for persons thus afflicted; (3) to coöperate with departments of health and education, reformatory and charitable institutions, courts, the Children's Home Society, and Associated Charities, and to recommend suitable treatment for persons coming to the attention of these organizations on account of mental or nervous conditions; (4) to acquire and disseminate knowledge of mental disease, feeblemindedness, epilepsy, and allied conditions, with a view to promoting a better understanding and enlightened public sentiment and policy in such matters.

New Jersey

In 1919, $400,000 was appropriated for the "erection of two treatment buildings for the prevention and curing of insanity." The 1920 legislature has also appropriated the same amount for the continuance of the construction of these two psychopathic buildings.

New York

The legislature passed, but the governor vetoed, a bill to provide for the "extradition of persons with unsound mind." In this connection, it may be of interest to know that such laws have been enacted in various years by Illinois, Maryland, Massachusetts, Nevada, Tennessee, and Wisconsin. The New York bill, which is similar to

the ones just mentioned, would apply to any person alleged to be of unsound mind found in this state who has fled from another state in which at the time of his flight (1) he was under detention in a hospital or other institution for the insane; (2) he had been previously determined to be of unsound mind by legal proceedings, and the control of his person had been acquired by a court of competent jurisdiction of the state from which he fled; or (3) he was subject to detention in such state on account of legal proceedings there pending to have him declared of unsound mind. The law would give the executive authority of the state from which the person fled the right to demand the delivery of such person from this state to that state in case that state had a similar law. The bill states that any proceedings must be begun within one year after the flight. The following is an outline of the procedure:

"Whenever the executive authority of any such state demands of the executive authority of this state any such fugitive and produces a copy of the commitment, decree, or other judicial process and proceedings, certified as authentic by the governor or chief magistrate of the state whence the person so charged has fled, with an affidavit made before a proper officer showing the person to be such a fugitive, it shall be the duty of the executive authority of this state to cause him to be apprehended and secured, if found in this state, and to cause immediate notice of the apprehension to be given to the executive authority making such demand, or to the agent of such authority appointed to receive the fugitive, and to cause the fugitive to be delivered to such agent when he shall appear. If no such agent appears within thirty days from the time of the apprehension, the fugitive may be discharged. All costs and expenses incurred in the apprehending, securing, maintaining, and transmitting such fugitive to the state making such demand shall be paid by such state. Any agent so appointed who receives the fugitive into his custody shall be empowered to transmit him to the state from which he has fled. The executive authority of this state is hereby vested with the power, on the application of any person interested, to demand the return to this state of any such fugitive."

Provision is made in the appropriation bill for increasing the number of after-care workers in the state hospitals for mental diseases, so that there will be one to each one hundred patients. One such worker for each of the state institutions for the feebleminded is also provided. These provisions are in accordance with recommendations of the Hospital Development Commission. Another recommendation of the commission, not favorably acted upon, was the creation of the

position of Director of Prevention and After-care, to have supervision of the mental clinics and social workers.

Chapter 794, Laws of 1920, provides for the retirement on pension of employees of state charitable institutions. By the terms of this act an employee must have served twenty-five years, or have reached the age of seventy years and have been thus employed not less than fifteen years. In either case he must be unable to perform his duties in a manner satisfactory to the head of the institution. The minimum amount of the allowance is $300 per year. In the case of those who have served twenty-five years, the annual payment is one-half of the salary received during the year immediately preceding retirement. A person employed less than twenty-five years is paid such proportion of one-half this salary as the number of years served bears to twenty-five years.

"Such teacher, attendant, assistant, or employee may be retired when such action shall be in the interest of the state, in the following manner: A teacher, attendant, assistant, or other employee shall be retired if a proper case as above provided, upon his or her application therefor, by the board of managers or trustees of such state institution in which he or she is employed, on the recommendation of the superintendent or other head of such institution. Such payment or annuity shall become effective and payable to such teacher, attendant, assistant, or employee from the first of the month immediately subsequent to the date of the meeting of the board of managers of such charitable institution taking action on the same and shall be payable for the natural life of such teacher, attendant, assistant, or employee in quarterly instalments."

Two bills were passed by the 1920 legislature for the establishment of a state psychopathic hospital to be located in New York City. Both of these were signed by the governor, but one is not effective since it was disapproved by the mayor of New York City. This latter bill would authorize the city to acquire a site for the hospital which it would lease to the state and authorize the State Hospital Commission to erect the hospital. The act that will become effective (Chapter 860) provides for the transfer of the Psychiatric Institute from Ward's Island to some site to be obtained in Manhattan or the Bronx and its expansion into a psychopathic hospital. This institution will serve as a reception hospital for incipient cases of mental diseases and as a teaching and research center for the entire system of the state hospitals caring for mental patients. It will also maintain an out-patient department.

This act authorizes $700,000 toward the construction of this hospital when a site is available, $25,000 of which are appropriated. It is hoped that an appropriation for a suitable site will be made by the 1921 legislature.

The State Farm for Women at Valatie has been transferred, by legislative enactment, from the State Prison Commission to the State Commission for Mental Defectives. It is to become an institution for mentally defective boys and men and is to be administered as a branch of the Rome State School for Mental Defectives. The higher grades of defectives will be transferred to this institution and arrangements for them will include their hiring out to farmers in the surrounding country.

Chapter 457, Laws of 1920, provides for an assistant mental diagnostician in the State Department of Education, to assist in the work of establishing special classes for backward children throughout the state. The position of mental diagnostician was established in the fall of 1918.

The general appropriation act makes substantial provision for new construction and permanent improvements at the institutions for insane, feebleminded, and epileptic. The sum of $3,321,280 and an additional authorization of $2,231,750 for these purposes were included in the general and specific appropriation bills this year.

Bills have been enacted by the legislature and approved by the governor which will increase the wages of employees of the state hospitals by about 20 per cent, to take effect July 1, 1920. A new salary schedule for the physicians at state hospitals has also been enacted, to be effective July 1, 1920. It provides for a higher minimum salary in all grades.

A special appropriation bill (Chapter 20) provides an authorization of $3,000,000 and an appropriation of $500,000 for the Creedmoor Division of the Brooklyn State Hospital.

Chapter 774, Laws of 1920, establishes a division for mentally defective delinquent women at the New York State Reformatory for Women at Bedford Hills. This division is to be subject to inspection by the State Commission for Mental Defectives and is to comply with the mental-deficiency law of the state in the matter of records, forms, colonies, and transfers to state institutions for mental defectives.

The law stipulates that the State Commission for Mental Defectives shall visit each institution for delinquent or criminal women that is controlled and supported by the state and after consultation with the superintendent or warden shall recommend to its governing board the commitment and transfer to this division of any woman who is found upon examination to be mentally defective to an extent to require supervision for her own welfare or for the welfare of others or of the community.

All commitments to this division must be in accordance with the provisions of the mental-deficiency law for persons arraigned or in custody on a criminal charge. (See Chapter 633, Laws of 1919, Article 4, Section 24a.) All commitments shall be for an indeterminate period. Any woman thus committed may be paroled or discharged by the board of managers upon recommendation of the superintendent of the New York State Reformatory for Women at Bedford Hills and the medical officer of the division, but she must not be paroled or discharged before she would have been from the institution from which she was transferred. This law authorizes the board of managers to lease for a period of not less than two years the property known as the Laboratory of Social Hygiene located at Bedford Hills, and to set aside a suitable portion of the property of the reformatory for the division for mentally defective women hereby established.

Pennsylvania

The governor has appointed a commission to revise and codify the laws dealing with the insane and feebleminded, in accordance with a law enacted by the 1919 legislature of Pennsylvania. The personnel of this commission is as follows: Judge Isaac Johnston, formerly Chairman of the Committee on Lunacy of the State Board of Public Charities; Dr. Owen Copp, Superintendent and Physician-in-chief, Department for Mental and Nervous Diseases of Pennsylvania Hospital, formerly executive officer of the Massachusetts State Board of Insanity; Dr. Theodore Diller, psychiatrist, of Pittsburgh, who was responsible for the introduction of the act creating the commission; Mr. Daniel C. Herr, a member of the Board of Managers of the State Hospital for the Insane at Harrisburg; and Dr. Charles H. Frazier, President of the Public Charities Association of Pennsylvania.

South Carolina

Act 345, Laws of 1920, is a revision of the laws relating to the South Carolina State Hospital. The 1919 legislature passed a resolution that the laws of the state pertaining to this hospital should be carefully

studied, and this act is the result of the recommendations of the committee appointed in accordance with the resolution.

The law states that the hospital shall be maintained solely for the support, custody, and treatment of persons with mental diseases. No other classes of patients are to be admitted except persons making voluntary application and those persons accused of crime who have been committed to the hospital for observation. There is a provision for emergency commitments which allows the superintendent to receive into his custody, and detain for not more than ten days, without an order from the probate judge, any person certified by two physicians as being in urgent need of treatment. The former law on this point limited the period to five days.

Voluntary admissions are also authorized by this law. This provision reads as follows: "The superintendent may, in his discretion, receive and detain in the hospital as a patient any person who is desirous of submitting himself for treatment, and who voluntarily makes written application therefor, and whose mental condition in the opinion of the superintendent is such as to render him competent to make the application. Notice of the reception of such voluntary patients shall be given the board of regents at its next regular monthly meeting. Such patient shall not be detained for more than ten days after having given notice in writing of his intention or desire to leave the hospital. The charge for support for such voluntary patients shall be governed by the rules of the hospital applicable thereto."

The law authorizes any judge of the circuit court to commit to the state hospital for a period of thirty days any person charged with a criminal offense, who shall, upon trial before him, be adjudged insane, or in whom there is a question as to the relation of mental disease to the crime. At the end of the thirty days the patient must be returned to the court if found sane, or duly committed by the judge, if found insane.

The regular commitment procedure is as follows:

"When a relative, friend, or other citizen interested is desirous of placing a person in the state hospital as a patient, he shall apply to the judge of probate of the county in which such person resides, make the affidavit in the manner and form required by the board of regents, and the judge of probate, without delay, shall proceed to investigate the case, and if in his opinion further investigation is necessary, he shall summon two duly licensed physicians to examine such person, and they shall under oath fill out and sign the medical certificate of insanity contained in the application for commitment, and if they agree that the person's mental condition is such as to necessitate commitment to the state hospital, the judge of probate shall then com-

plete the paper required of him by the board of regents and immediately forward it to the superintendent for his approval. The superintendent is hereby authorized to receive at his discretion persons transmitted from other hospitals, and to detain them for a period not longer than ten days, provided the person interested in the transfer makes application as required by the board of regents. The person making application shall, within the prescribed time, furnish the superintendent with the necessary papers or remove the patient from the institution, and failing therein, be liable to the hospital for the expense incurred and a penalty of fifty dollars, which may be recovered by the hospital in an action in any court of competent jurisdiction. On receiving the application and the answers to the specified interrogatories, the superintendent shall promptly forward a reply to the judge of probate stating whether or not the person can be received. If the application is not approved, the superintendent shall accompany its return to the judge of probate with a written statement giving his reasons therefor.''

Nonresidents of the state are not to be admitted except in emergency cases, special provisions and regulations being made therefor.

The superintendent, under the authority of the board of regents, may parole any convalescent patient at the request of relatives or friends, for a period not exceeding six months. The former law limited the parole period to three months.

Provision is made for the transfer of any person suspected of having mental disease confined in any other state institution to the South Carolina State Hospital for examination and observation.

The National Conference of Social Work

The Forty-seventh annual Meeting of the National Conference of Social Work was held in New Orleans, April 14–21. The program of the Division on Mental Hygiene, under the chairmanship of Dr. C. Macfie Campbell, had as its general theme *The Requirements of the Normal and Handicapped Individual in School, Workshop, and Home for a Healthy Personal Balance.* The general session of the division was a joint meeting with the Division on Delinquents and Correction, the addresses being *Some of the Tasks of Organized Work in Mental Hygiene,* by Dr. Thomas W. Salmon, Medical Director, the National Committee for Mental Hygiene, New York; *The Desired Minimum of Sociological Insight for Workers with Delinquents,* by Arthur J. Todd, Labor Counsellor, B. Kuppenheimer and Company, Chicago; *The Desired Minimum of Medical Insight for Workers with Delinquents,* by Dr. C. Macfie Campbell, Johns Hopkins Hospital,

Baltimore; and *Methods of Raising the Morale of Public Opinion for Effective Social Service,* by Roland F. Beasley, Commissioner of Public Welfare, Raleigh, North Carolina.

The programs of the section meetings of the Mental Hygiene Division were as follows:

1. Topic: *The Human Requirements of the Individual Industrial Worker.*

The Mental Hygiene of Industry; Report of Progress on Work Undertaken Under the Engineering Foundation (a report of work done in collaboration with the late E. E. Southard, Director, Massachusetts State Psychiatric Institute, Boston), by Mary C. Jarrett, Associate Director, Smith College Training School for Social Work.

Nervous Breakdown of Women and Minors in Relation to Night Work and Long Hours, by Mrs. Florence Kelley, National Consumers' League, New York.

The Personal Problems of a Group of Workers, by Dr. Anne T. Bingham, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore.

2. Topic: *The Mentally Handicapped: Their Extra-institutional Supervision and Utilization.*

The Rehabilitation of Defectives and Delinquents, by Dr. Charles Bernstein, Superintendent, Rome State School for Mental Defectives, Rome, New York.

Individual Variations in Mental Equipment, by Dr. Augusta F. Bronner, Assistant Director, Judge Baker Foundation, Boston.

The State Hospital and the Parole System, by Everett S. Elwood, Secretary, State Hospital Commission, Albany.

3. Topic: *The Study of Individual Traits and Difficulties.*

Social Work and the National Committee for Mental Hygiene, by V. May MacDonald, Organizer of Social Work, the National Committee for Mental Hygiene, New York.

The Industrial Cost of the Psychopathic Employee, by Mrs. Margaret J. Powers, Mental Hygiene Committee, State Charities Aid Organization, New York.

Mental-Hygiene Problems in Truant and Delinquent School Children, by Dr. Sanger Brown, II, Physician in Charge, Mental-Hygiene Clinic, Public School 37 (Manhattan Probationary School), New York.

4. Topic: *The Unstable Individual in School, Court and Institution.*

(Joint session with Division on Delinquents and Correction.)

The Problem of Social Case Work with Children, by Dr. Jessie Taft, Director, Department of Child Study, Seybert Institution, Philadelphia.

Justice in the Social Court for the Mentally Afflicted, by Charles L. Brown, President Judge, Municipal Court, Philadelphia.

Disciplinary Measures in the Management of the Psychopathic Delinquent Woman, by Mrs. Jessie D. Hodder, Superintendent, Reformatory for Women, Framingham, Massachusetts.

5. Topic: *The Demand from the Community for Help in Mental Hygiene.*

The Appeal from the Community and the Response, by Dr. Frankwood E. Williams, Associate Medical Director, the National Committee for Mental Hygiene, New York.

The Mental-Hygiene Requirements of a Community: Suggestions Based upon a Personal Study, by Dr. Thomas H. Haines, Field Consultant, the National Committee for Mental Hygiene, Jackson, Mississippi.

Outline for a State Society of Mental Hygiene, by Dr. E. Stanley Abbot, Medical Director, Mental-Hygiene Committee, Public Charities Association of Pennsylvania, Philadelphia.

Dr. Thomas W. Salmon, New York, was elected chairman for the coming year, Dr. William A. White, Washington, vice-chairman, and Miss Edith M. Furbush, New York, secretary.

Mental Hygiene—American Public Health Association

One session of the Section of Sociology, at the coming annual meeting of the American Public Health Association, is to be devoted to the subject of mental hygiene. Announcement has been made that the date of the meeting has been changed to September 13-17, in order to avoid a conflict with a California state election.

Meeting of the American Neurological Association

The American Neurological Association held its forty-sixth annual meeting in New York City, June 1–3. The program included a number of papers of interest to students of mental hygiene. Some of these were: *A Psychological Study of a Medium,* by Dr. Morton Prince, Boston; *A Diagnostic Clinic for Adolescents; Purpose and Organization,* by Dr. Pearce Bailey, New York; *Nervous Signs and Symptoms as Related to Certain Causations of Conduct Disorder,* by Dr. William Healy, Boston; *A Study of the Socially Maladjusted*

(*Psychopathic Personalities, Morons, and Constitutional Inferiors*), by Dr. L. Pierce Clark, New York; *The Dementia Praecox Problem*, by Dr. Henry A. Cotton, Trenton, New Jersey; *Graduate Neuropsychiatric Instruction* by Dr. T. H. Weisenburg, Philadelphia; and *The Psychoneurotic Element in Juvenile Delinquency*, by Dr. Herman M. Adler, Chicago. An interesting paper, illustrated by moving pictures, on hysterical paralysis in soldiers, was contributed by Dr. Gustave Roussy, of the Neurological Society of France.

Annual Meeting of the American Medico-Psychological Association

The American Medico-Psychological Association held its seventy-sixth annual meeting at the Hotel Statler, Cleveland, Ohio, June 1–4. The program of the Mental Hygiene Sessions, which were held on June 2, was as follows:

1. Topic: *Organized Work in Mental Hygiene*

   The Practical Aims of the National Committee for Mental Hygiene, by Dr. Thomas W. Salmon, Medical Director, The National Committee for Mental Hygiene.

   The Field of a State Society for Mental Hygiene, by Dr. E. Stanley Abbot, Medical Director, Mental Hygiene Committee, Public Charities Association of Pennsylvania.

   Ten Years' Work of the Illinois Society for Mental Hygiene, by Dr. Ralph P. Truitt, Medical Director, the Illinois Society for Mental Hygiene.

2. Topic: *The State Hospital and Mental Hygiene*

   What an Adequate Program in Mental Hygiene Involves for a State Hospital System, by Dr. George M. Kline, Director, Massachusetts Commission on Mental Disease.

   The State Hospital's Part in the Mental-Hygiene Movement, by Everett S. Elwood, Secretary, New York State Hospital Commission.

3. Topic: *Mental Hygiene and Childhood*

   Mental Problems in Delinquent School Children, by Dr. Sanger Brown, II, Physician in Charge, Mental-Hygiene Clinic, Public School 37, Manhattan.

   Childhood: The Golden Period for Mental Hygiene, by Dr. William A. White, Superintendent, St. Elizabeths Hospital, Washington, D. C.

   The Experiences of the Child: How the Experiences of Childhood Affect Character, by Dr. C. Macfie Campbell, Johns Hopkins Hospital, Baltimore.

4. Topic: *Special Problems in Mental Hygiene*

Educational Publicity in Mental Hygiene, by Dr. Frankwood E. Williams, Associate Medical Director, the National Committee for Mental Hygiene.

New Fields for Mental Hygiene, by Dr. W. B. Cornell, Physical and Mental Diagnostician, the State Department of Education, Albany.

An Extension Course in Psychiatric Social Service, by Dr. Harold I. Gosline, the State Hospital for Mental Disease, Howard, Rhode Island.

Other sessions were devoted to neuropathology and allied subjects and to clinical psychiatry.

American Association for the Study of the Feebleminded

A program of unusual interest was presented at the Forty-fourth Annual Session of the American Association for the Study of the Feebleminded, held in Cleveland, Ohio, June 4–5. The papers were stimulating and were followed by lively discussions. Among the subjects treated were *State Institutions for the Feebleminded: Their Organization,* by Dr. W. B. Cornell, Physical and Mental Diagnostician, State Department of Education, Albany; *Mental Deficiency Work of the National Committee for Mental Hygiene,* by Dr. V. V. Anderson, Associate Medical Director, the National Committee for Mental Hygiene; *Our Obligations Towards the Feebleminded,* by Dr. Walter E. Fernald, Superintendent, Massachusetts School for Feebleminded, Waverley, Massachusetts; *Public School Clinics in Connection with a State School for the Feebleminded,* by Dr. Edith E. Woodill, Senior Assistant Physician, Massachusetts School for the Feebleminded; *The Almosts,* by Dr. Helen MacMurchy, Inspector of Feebleminded, Toronto; and *The Out-Patient Clinic Connected with State Schools for the Feebleminded,* by Dr. Walter E. Fernald.

Provision for the Early Treatment of Mental and Nervous Disease in England

The following letter to the editor of the *London Times,* signed by Thomas Barlow, Clifford Allbut, G. H. Savage, Frederick W. Mott, Robert Armstrong-Jones, John Lynn-Thomas, William McDougal, Charles S. Myers, G. Elliot Smith, R. Percy Smith, Bedford Pierce, Robert B. Wild, David Drummond, A. H. Trow, M. Thomas and E. Goodall, will be of interest to American readers as showing the efforts now being made in England to provide for the early treatment of patients with nervous and mental disease:

To the Editor of The Times, Sir.—Permit us through the medium of your columns to draw attention to the urgent need of reform in the methods of dealing with disorders of the mind in this country. The insane are still dealt with under the provisions of the Lunacy Act, 1890. In 1914 the Medico-Psychological Association of Great Britain and Ireland, after careful inquiry into the status of British psychiatry, urged reforms in the methods of treatment of incipient mental disease, and the provision of facilities for study and research. In November, 1918, this association adopted a report of a subcommittee appointed to consider the amendment of the existing lunacy laws. This report states that there are very few facilities for patients who are threatened with mental breakdown to obtain skilled treatment until they are placed under certificates under the Act, whereas the early symptoms of disorder often occur long before certification is possible; that, owing to treatment being delayed, the most valuable time for adopting measures to secure early recovery is lost; that the public, which is alive to the material and moral damage which certification often inflicts on the patient and his relatives, refuse to resort to it, even when it has become possible, and thus still further postpone the adoption of efficient treatment; that where certification has to be resorted to, the subsequent course of events often shows that this might have been avoided had there been facilities for treatment under other conditions; that many medical practitioners, having had no opportunity of gaining knowledge of the manifestations and treatment of mental disorders in their early stages, fail to recognize the seriousness of the condition, and are, further, deterred by the necessity of certifying the patient from advising suitable treatment.

The existing Lunacy Act, protecting, as it does, society, and safeguarding the liberty of the subject, allows insufficient scope for the treatment and cure of the patient.

The position—and we cannot believe that the public can be aware of it—is that a very large class of the community is debarred from obtaining advice and treatment (except such as can be given in an outpatient department, and even this provision is extremely rare) in the early stages of disease, and this owing to the operation of laws designed mainly with a view to protecting the interests of that class.

The proposals made by the experts composing this subcommittee to remedy the defects summarized correctly represent the view of all with practical knowledge of the subject. These aim at the provision of treatment in the early and curable stages of mental disorder without certification, which provision would be rendered possible by a short amending bill to the Lunacy Act, embodying the reforms most urgently needed. The proposals are, in brief, as follows: The provision of clinics—the so-called psychiatric clinics—in large centers of

population, and especially in connection with the general hospitals and where schools of medicine exist; the extension of the system of voluntary admission (which now obtains in respect of licensed houses and registered hospitals for the insane), so that patients, whether of the private or rate-aided class, may place themselves for treatment in county borough mental hospitals; or further provision for the private-patient class, so that, with the approval of the board of control, such may be received without certification (but with the cognizance of the central authority) into homes, privately owned or supported wholly or partly by voluntary contributions, and also into existing public and private mental hospitals (" licensed houses ") ; also received, with the sanction of the board, as single patients, without certification, provided that a medical practitioner gives a written recommendation, stating that suitable treatment can be obtained in the proposed house.

Of the above proposals, that concerned with the establishment of clinics in psychiatry—with in- and out-patient departments—as an integral part of the general hospital system is the most important. Our main hope of avoiding the never-ending extensions to existing asylums lies in the operation of these clinics. In this respect this country is deplorably backward as compared with other European countries, great and small, with the United States, and with some of the component parts of the British Empire. This is the more regrettable since it is in these clinics that students and the future holders of posts in mental hospitals should be taught and all available means of research be provided. For none of these purposes is the present " asylum " system adequate. In such clinics patients would be received without reception orders or certificates, and would be subjected to the minimum of official supervision; and on these lines they might be treated for a stated period—not less than six months. The late Dr. Henry Maudsley was the first to give practical expression to the urgent need for these clinics when, eleven years ago, he made his munificent gift—ultimately amounting to £40,000—to the London County Council, which rendered possible the erection of the Maudsley Neurological Hospital, Denmark-hill. This hospital has rendered most valuable service during the war in the treatment of patients and the instruction of medical officers. It is gratifying to think that Dr. Maudsley's wish that his hospital should be used for the treatment of early cases of mental disorders, without certification, and for the teaching of psychiatry, is likely ere long to be realized.

In this connection it will be of interest to recall that in the case of mentally disordered soldiers the army authorities arranged, during the war, that they be received into military mental hospitals without any orders or certificates. These men were, in the first instance, not sent to their asylums until the mental disability had lasted for a period

of nine months and was deemed incurable; later it was decided that this step should be taken after observation and treatment for such an extended period as was necessary to form the opinion that recovery was unlikely. Large numbers of the men were received in very early phases of the disease. The immense boon and solace this wise step conferred upon the patients and their relatives are best known to those physicians who have been connected with these hospitals. If these men could be treated thus whilst in khaki, they could, and should, be similarly treated as civilians, and under far better medical conditions than in asylums. The war has in this, as in other instances, been a means of education.

The necessity of carrying out the reforms above outlined has been repeatedly urged in the leading organs of the medical profession. That the board of control, the central authority in matters appertaining to the insane, is well aware of the pressing need for them is sufficiently shown by the recommendations contained in its fourth and fifth annual reports for the years 1917 and 1918. From the latter it appears that the board has submitted to the Lord Chancellor and the Secretary of State the heads of a bill, with a recommendation that it should be introduced into Parliament at the earliest practicable date, and be pressed forward as a measure of urgent importance to the health and welfare of the people. In October, 1918, a deputation representing the National Council of Mental Hospital Authorities was received at the Home Office, and it was abundantly clear that that department was in sympathy with the representations made with a view to these reforms. Up to the present time, however, we have no evidence that any step whatever has been taken to the desired end.

We believe it to be the fact that in the present Parliament there are a number of medical men and others interested in this matter, and there is a reasonable hope that such a bill would meet with sympathy and a swift passage into law.

We would, therefore, earnestly appeal to you to lend your powerful support in this matter, so that the introduction by the government of the legislation necessary to facilitate, on the lines indicated, the early treatment of mental and allied nervous disorders may be no longer delayed, and a grievous injustice to a very large class of suffering humanity may be removed.

Effects of the War Upon Population of English Hospitals for Mental Disease

Dr. Douglas A. Thom is collecting information in England for the National Committee for Mental Hygiene regarding some of the effects of the war upon mental-hygiene problems. Among some information

received from him is that concerning the remarkable diminution of population in public institutions for the insane. Between January 1, 1918, and January 1, 1919, there was a decrease in the number of patients of 9,108. The entire decrease in institutional population from January 1, 1915, to January 1, 1919, was 28,119.

Several causes contribute to this striking substitution of a decrease for the constantly increasing number of patients with mental diseases that had been taking place prior to the war. By far the most important was an enormous death rate—20 per cent during 1918, and nearly as high a rate during the other years of the war. When the tale of the privations endured by the civil populations of the countries at war is fully told, one of the saddest chapters will be that which refers to the removal of the insane from their own institutions, their crowding together in others, their premature return to their homes, and the havoc that disease, particularly tuberculosis, waged among them. An indication of how little our country was touched by the war is seen in the fact that no such decrease in the number of patients in institutions occurred in the United States during its participation.

Need for Teachers in Occupational Therapy.

In the transition from war service to service in time of peace, with its change of the center of interest from the military hospital to the civil hospital, occupation therapy is not only holding its own, but is rapidly gaining ground. One phase of this development is a stumblingblock to progress—the lack of trained teachers to fill positions in this field. Although a number of the training schools that sprang up during the war have been continued, the classes have generally been small, and the available supply of teachers does not meet the demand.

Boston, St. Louis, Chicago, and Philadelphia have schools of occupation therapy, and Milwaukee-Downer College, Milwaukee, and Teachers College, Columbia University, offer courses in this subject as a regular part of the college curriculum. Such courses lead to college certificates or degrees.

The course at Teachers College is under the direction of the Department of Nursing and Health. It includes various crafts, drawing and design, personal and general hygiene, physiology and anatomy, psychology and mental hygiene, and social science. The theory and practice of teaching the sick are especially emphasized. This is a practical course through which all the other subjects are correlated and applied to the hospital work. The early practice work is given under supervision at Montifiore Hospital, after which students are placed in other hospitals for further experience.

Montifiore Hospital offers six scholarships in occupation therapy at Teachers College, covering the expense of tuition. Applicants for these scholarships should apply to the Director of Occupation, Montifiore Hospital, 210th Street, New York.

This field of teaching makes a strong appeal to those who are interested in entering upon some practical form of service and also to those who are interested in handicrafts. The salaries and hours compare favorably with those of other teaching fields and are somewhat more advantageous than the hours and salaries of nurses. The demand for teachers, particularly in state hospitals and sanatoriums, promises to increase steadily, and the shortage of trained teachers is a real hindrance to the development of the work.

Clinics for Mental Defectives in New York State

In connection with a state-wide plan, the New York State Commission for Mental Defectives has, during the past year, established ten clinics for mental defectives.

These clinics are conducted in coöperation with other state departments, notably the State Hospital Commission and the Department of Health, the mental clinics of the state hospitals being largely used as a basis. These joint clinics are located as follows:

Binghamton	Community Service Building First Monday of the month, 9 a. m. to 5 p. m.
Mineola	Nassau Hospital Every Monday, 1 to 3:30 p. m.
Middletown	Council Chamber, City Hall Second Tuesday of the month, 9 a. m. to 5 p. m.
Yonkers	St. Joseph's Hospital Second and fourth Wednesdays, 2:30 to 5 p. m.
Jamestown	Visiting Nurse Association Dispensary Third Wednesday, 1 to 3:30 p. m.
Watertown	City Hospital Third Wednesday, 9 a. m. to 5 p. m. St. Joachim Hospital Thursday (day following clinic at City Hospital), 9 a. m. to 5 p. m.
Utica	Free Dispensary Friday and Saturday following Watertown Clinic, 9 a. m. to 5 p. m.
Schenectady	Health Center Last Wednesday of each month, 1 to 5 p. m.
Plattsburg	Champlain Valley Hospital Each Wednesday, 10 a. m. to 4 p. m.

New Sing Sing Prison now under construction, Psychiatric Building in the foreground at the left

Ithaca City Hospital
First Saturday of the month, 10 a. m. to 5 p. m.

Further details as to the organization, purpose, and results of these clinics are contained in the article published in this number entitled *Clinics for Mental Defectives in the State of New York*, by Dr. William C. Sandy, Psychiatrist of the State Commission for Mental Defectives, who has been engaged in establishing such facilities.

The Clinic Building at the New Sing Sing Prison

A recent number of *The American Architect* contains a short article by Dr. Walter B. James on the Clinic Building of the new Sing Sing Prison, now under construction.

"It is many years," Dr. James says, "since men began to realize that their diseases were not the result of a divine purpose, and so they have attempted, first, to understand their origin, through study and analysis, and then from these to discover means of prevention and cure. As a result of these efforts the prolongation of human life has more than doubled, and the disease and suffering rate has markedly diminished and is still diminishing.

"To-day, resignation and patient submission in the presence of disease of the body are no longer virtues. Mental disease has only more recently been looked at from this same viewpoint, and gratifying headway is being made in this direction. The world is just beginning to realize that misbehavior or antisocial behavior presents to society a problem somewhat similar to that of physical and mental disease.

"I do not mean that misbehavior is necessarily the result of or associated with disease, either physical or mental, although this is often the case, but that it presents an analogous problem to society, and that it should be attacked in the same manner—that is, through scientific analysis and classification, the discovery of causes, probably very complex, and the application of remedies, probably chiefly preventive and based upon these causes. Only in this way can it be hoped to turn this costly waste product of social life into a useful by-product.

"When the 'Sage Prison Bill' became a law, providing for the demolition of the old Sing Sing cell block and the erection there of a new study, classification, and distributing prison, and creating the 'State Commission on New Prisons,' New York State committed itself to a new and more intelligent policy toward its offenders and toward the whole problem of misbehavior. The new commission, commanded to carry out the above and other provisions, soon found itself confronted by problems that belonged essentially to modern

medical science, and it turned to the National Committee for Mental Hygiene for counsel, and an advisory medical committee was formed. About a year before this, realizing the need of a more thorough psychiatric study of criminals along the lines that had been followed so well by Dr. Healy at the Juvenile Detention Home in Chicago, the National Committee had placed Dr. Bernard Glueck in Sing Sing Prison, with the consent and sympathy of the Department of Prisons, to carry out a complete mental analysis of all new admissions.

"The results of Dr. Glueck's studies have been published in full in MENTAL HYGIENE, and elsewhere, and form a valuable foundation for the scientific handling of the mental side of prisoners.

"The commission and the state were fortunate in having Mr. Pilcher, the New York State Architect, to translate these ideals into actual construction, and now the completion of an important part of the plans, including the Clinic Building, and, most of all, the final assigning of the contract for the erection, insures the carrying out of this interesting and important project.

"Mr. Pilcher has thrown himself into the undertaking with singular diligence and intelligence, and has entered thoroughly into the spirit of modern scientific treatment and research.

"The newest and most original feature of the prison is the Clinic Building, in which the study and classification of the prisoners is to take place, and in which, as well, the general medical and surgical work of the institution will be carried on. It provides for the complete physical and mental examination of every inmate. It contains the hospital wards, dispensary, operating rooms, and laboratories and X-ray plant, and, indeed, it corresponds on a small scale to the hospital of any community, but differs from this in that it assumes that the whole population of the community may be abnormal, and therefore requires that every member of it shall at some time pass through the clinic for purposes of study and analysis. For this reason, the psychiatric or mental division of the clinic is relatively more accentuated.

"It requires courage to attack such a problem as this, an attack that may carry us into troublesome social fields. It seems to be a fact, however, that no other method gives promise of relieving society of any considerable part of this burden of suffering and cost. We must not expect ever to be entirely rid of this burden, just as we shall never be rid of the burden of physical and mental disease; but just as science has diminished and is still diminishing these latter, so we have reason to believe that similar scientific methods, properly applied, will diminish the burden of antisocial behavior, and help us to approach the irreducible minimum, a minimum which must probably always exist in a human world like ours, but a minimum from which we are at present still very far."

Three-day Consultation Clinics

The New York State Department of Health, in coöperation with the New York State Hospital Commission, is developing a plan for three-day consultation clinics. A conference was held recently, attended by representatives from the New York State Charities Aid Association, the State Department of Education, the State Commission for Mental Defectives, the Red Cross, and other organizations, at which counties were selected in which there were very few, if any, clinical facilities. For several weeks in advance of the holding of a clinic, various workers—physicians, nurses, and social workers—from the different organizations go to a county to study the needs and to get knowledge of such patients—nervous, mental, surgical, tuberculous, sick children—as are in need of clinical attention. The first clinic was held at Geneseo, Livingston County, on June 8, 9, and 10. Some twenty-six physicians, representing various specialists, were in attendance. Some 600 patients were brought to the clinic and were referred for examination to the various departments. Eventually, the family physician and others interested will receive a report of the findings and recommendations from the state department of health, no treatment being instituted by the consultants at the clinic. A similar clinic was held at Norwich, Chenango County, for three days, beginning June 30.

A Mental-Hygiene Clinic at Mount Sinai Hospital

In connection with the reorganization of the neurological department of the Mount Sinai Hospital, a clinic for mental hygiene has been established in the out-patient department. It is in charge of Dr. C. P. Oberndorf, and will have direct connection with the hospital proper. It is also intended that purely mental cases from the neurological department of the dispensary will be cared for by the mental-hygiene clinic. For the present it will be held on Monday, Wednesday, and Friday mornings.

Course in Psychiatric Social Work at Johns Hopkins

The Johns Hopkins Hospital Social Service Department, Baltimore, Maryland, offers a course in psychiatric social work to a limited number of students who have had one year of training in an accredited school of social work, or its equivalent, and to graduate nurses.

Lectures and field work will cover one year, beginning October 1, 1920. A vacation of one month will be allowed. Application must be made before August 15, 1920. The tuition for the course is $100.

Teaching of Psychiatry at Harvard Medical School

It was announced on June 6th, 1920, by the General Education Board that an appropriation of $350,000 had been made to the Harvard Medical School to promote the teaching of psychiatry. This recognition of the importance of including mental medicine in the training of physicians by a foundation with so deep an interest in the problems of medical education and their bearing upon human life and happiness cannot fail to have far-reaching results. There are many signs that in this country as in England the war has brought sharply to the attention of the medical profession the great practical importance of mental disorders and other abnormal mental reactions and the responsibility of the physicians in equipping themselves to deal with these disorders instead of leaving the whole field of mental medicine to those who possess no training in the management of disease.

Mental-Hygiene Courses at Lehigh University

At the summer session Lehigh University offers a number of special courses in mental hygiene. One course, designed for teachers of special classes, supervisors, clinical examiners, and teachers of regular classes, is on the teaching of exceptional children. A second course is offered on mental surveys in school systems. Special lecturers in this course are Dr. V. V. Anderson, Associate Medical Director of The National Committee for Mental Hygiene, in charge of work in mental deficiency; Mr. Oliver P. Cornman, Associate Superintendent of the Public Schools of Philadelphia; Captain Gary C. Myers, Director of the Recruit Educational Center at Camp Upton, New York; Mrs. S. D. Porteus, Director of Research at the Training School, Vineland, N. J.; and Mr. M. R. Trabue, Director of the Bureau of Educational Service, Teachers College, Columbia University. Other courses offered are Education of the Mentally Deficient and Abnormal, Occupational Therapy and Pre-vocational Work, Mental Clinic, Mental Hygiene, and Supervision of Special Classes. Instructors and special lecturers in these various courses include Dr. E. Stanley Abbot, Medical Director, Mental Hygiene Committee, Public Charities Association of Pennsylvania; Dr. H. I. Klopp, Superintendent, and Dr. H. F. Hoffman, Assistant Superintendent, of the Homeopathic State Hospital, Allentown, Pennsylvania; Miss Meta L. Anderson, Supervisor of Classes for Defectives, Newark, N. J.; Miss Ada K. Hartzell, Occupational Therapist, Teachers College, Columbia University, formerly Teacher of Special Class, Harrisburg, Pa.; Professor L. R. Drown and Professor Percy Hughes of Lehigh

University. On each Saturday morning during the summer session special lectures on mental hygiene will be given. These lectures will be open to the general public; physicians, social workers, and educators are especially invited.

A New Publication in the Field of Mental Defect

The council of the Central Association for the Care of the Mentally Defective, London, in November, 1919, decided to issue a paper "especially designed to meet the long-felt want of some means of communication between the various branches of work for the mentally defective." The first number of *Studies in Mental Deficiency*, as the new publication is called, was brought out in January, 1920. Besides contributed articles, the paper contains a department for news items, for correspondence, and for book reviews. The editors ask for the coöperation of all who are interested in work for defectives. They welcome suggestions as to how the paper can be made more helpful, and they are glad to receive questions on points covering special departments of the work, such as administration problems, legal difficulties, or queries on the staffing and equipment of institutions. These questions will be answered by experts or after consultation with experts. Information for the "News and Notes" department is especially desired. Communications should be addressed to the Central Association for the Care of the Mentally Defective, Queen Anne's Chambers, Tothill Street, S. W. 1, London.

A Pamphlet on New York State Institutions

The New York State Charities Aid Association has recently issued a helpful pamphlet entitled *The State Institutions: How to Use Them Wisely*. The institutional system of the state of New York makes provision for persons of the following classes: (1) mentally diseased, (2) mental defectives, (3) epileptics, (4) delinquents, (5) blind children, (6) deaf children, (7) crippled children, (8) Indian children, (9) veterans and their families, (10) cases of incipient tuberculosis. The pamphlet gives the location of the various state institutions and outlines the procedure of admission to each; also brief paragraphs on facts about mental disease, facts about mental deficiency, etc.

The Municipal Court of Philadelphia

An interesting account of the work of the Municipal Court of Philadelphia was given in an address delivered before the Mental Hygiene Division of the National Conference of Social Work, at

New Orleans, by the Honorable Charles L. Brown, president judge of the court. The court is composed of five divisions—a juvenile division, of which the House of Detention for Juveniles is a part, a domestic-relations division, a men and boys misdemeanant's division, a criminal division for women, and one for men. One of the important features of the court is its medical department, consisting of a volunteer board and a paid staff. The volunteer board has at present five members—Dr. Charles B. Penrose, chairman, Dr. J. Montgomery Baldy, Dr. Charles W. Burr, Dr. D. J. McCarthy, and Dr. S. D. W. Ludlum. Dr. Thomas A. Shallow is the chief of the paid staff, and Dr. Samuel Leopold head of the neuropsychiatric department. Judge Brown's address was in part as follows:

"In addition to the juvenile division, the municipal court has jurisdiction in non-support and desertion cases; these cases come in the domestic-relations court. It also has jurisdiction in the cases of disorderly children, boys and girls between the ages of sixteen and twenty-one, as well as in all cases of persons arrested for disorderly street-walking. In addition it has criminal divisions for the trial of the lesser crimes—larceny, petty thefts, shop lifting, etc. Bastardy and fornication proceedings involving the support of illegitimate children come in this latter court.

"The treatment of all of these cases, except those of disorderly girls and prostitutes, is altogether extra-mural, and is largely a matter of diagnosis, the medical agencies of the city being used for treatment. However, for the prostitutes as well as in the cases of young girls who are infected, we have a medical ward and a hospital.

"Our Women's Misdemeanant Building is a three-story building. On the second floor is a medical ward for the treatment of venereal disease. On the third floor is the detention home with private rooms for the young girls. All of these undergo a medical examination consisting of a general examination to determine the physical condition and a specific examination with scientific tests to determine the presence of venereal disease. The next step is a psychiatric test which reveals the psychopaths, the drug addicts, the hysterical, and those who have nervous conditions. The next step is the psychologic or psychometric test, which indicates what may be the girl's mentality. All these tests and examinations are given by women. The skin specialist is a woman, the general medical examiner is a woman, the gynecologist is a woman, the psychiatrist is a woman, and so is the psychologist.

"After these various steps have been taken, the girl is ready for presentation in court. The judge has before him a complete picture of the girl as regards her history, her social life, her physical condition, and her mental condition. He bases his decision accordingly.

If she needs psychiatric treatment, she receives it. If she needs commitment to an institution for mental disease, that is also arranged. For the treatment of venereal disease we have our own hospital, the Gynecean Hospital, donated to the use of the court by the board. That means that the observation of the psychiatrist is continued during the period of treatment for venereal disease.

"In the other divisions of the court, where detention is not part of the proceedings, as in the juvenile and domestic-relations divisions, the cases are referred by the probation officers to the medical department for physical diagnosis, and to the neuropsychiatric department for psychiatric and psychometric diagnosis. For example, we are trying to have all juveniles not arrested for delinquency, and therefore not subject to examination in the House of Detention, examined on the day of the court hearing, so that the judge will know the kind of child he is dealing with. Our mental examinations of such children have revealed to us how important it is to extend the service to other divisions of the court.

"Physical and mental examination prior to court hearing are very important when it comes to a question of placing children, not only when they are feebleminded, but when they are supersensitive or highly nervous. We had one little girl who had been cared for by a stranger after her mother had been committed to a state hospital. She grew very fond of her foster mother. However, the foster mother was not of the same religion as the child; therefore the court was asked to place her in another home of the same religion. The court was reluctant to do so because the psychiatrist told us that the child was more than high-strung and that it might be a serious thing to do in view of her heredity. Circumstances, however, made it necessary to make the change to another home. The psychiatrist's fears were more than fully realized. The disturbed, emotional child attempted suicide, but fortunately was saved. This case, rather than that of the wild-eyed, deranged individual usually pictured when the layman thinks of the mentally afflicted, illustrates the type of case—adult, adolescent, and juvenile—that is seen most frequently in a social court.

"The majority of our cases, by far, do not need commitment, but do need medical oversight and supervision, and all need social or probationary supervision. Dr. Leopold tells me that the majority of our cases involve disturbed states of personality—individuals with mind 'twists' or whose emotional life is abnormal and whose emotional reactions are strong, leading into conduct disorders of various kinds.

"It may interest and surprise some of you to know that our examin-

ers find that most of the girls in the misdemeanants' division of the court are not feebleminded, the characteristic, as I have just stated, being lack of emotional balance.

"Two observations in this connection may be worth making: first, that the girls of subnormal mentality were probably weeded out at an earlier age in the juvenile court; second, that in the case of the older girls arrested for prostitution, one might reason that the business in which these girls are engaged is a calling requiring, to avoid its traps and dangers, a skill that it would be impossible for a feebleminded woman to exercise. Here, again, we may have emotional disturbances or character defects.

"We have very scant figures as to the mental condition of the people who come to us in the domestic-relations court. We have here the insanities, paranoia, sex perversion, and other forms of mental breakdown, due to failure or unsatisfactory adjustment to life.

"With the criminal cases we have not done as much as we might, because we are here handicapped by law, which prevents us from making medical examinations before trial. Because of the court calendar, it is difficult to call cases up again to get examinations later, before sentence is passed.

"Dr. S. D. W. Ludlum—a member of our medical board and a well-known psychiatrist—made a remarkable study of a group of the young girls under the care of the court, in order to establish a technique for the social and judicial handling of these girls. Dr. Ludlum made an effort to classify those referred to him as superiors, equals, inferiors, not according to the way we think of them, but according to the way they esteem themselves in relation to others, their environment, and the forces operating against them. Do they think themselves better than others, the equals of others, or not so good as others? (As a judge, it seems to me that it is sound judicial philosophy to put oneself in the place of the individual at the bar in order to discover, not how one would act if one were in that girl's or that boy's place, but how the boy or girl reacts being what he or she is under the circumstances.)

"These girls, 440 of them, were all incorrigible girls—not prostitutes, although they may have had sex experiences. I should like to quote from the report, which is still in manuscript:

" 'The incorrigible, first of all, is an individual whose instincts are unequally developed. In her all aggressive impulses—self-assertion, pugnacity, curiosity—are strong. All restraining impulses—repulsion, fear, tender emotion—are weak. As self-assertion, which makes for "nonconformity," is high, repulsion, which would most certainly thwart self-assertion, is low. And the incorrigible shows lack of

repulsion, not only to law-breaking, but even to filth and poor housing conditions.

"'The kind of incorrigible is determined by the particular instincts in power. Here self-estimation is used as a basis of classification. According to self-estimation, or the answer to the question, "Am I as good as, better than, or worse than the people or forces with whom I live?" incorrigibles fall into three groups—superiors, equals, and inferiors. While all are unbalanced in development of instinct, the superiors and inferiors stand out prominently. The former have the most pugnacity and self-assertion, whereas the latter, the inferiors, have too little self-assertion and pugnacity to carry out their real impulses. Consequently, these are very weak and easily led into wrongdoing by stronger companions.'

"It is apparent that the incorrigible girl needs a leveling or balancing process. The girls who think themselves superior and have strong instincts may need custodial care; the weak girls need strengthening and encouragement. Of course, one can become too doctrinaire and too rigid in the application of such a scheme, but I believe it will lead to a more scientific handling and perhaps a better understanding of the incorrigible girls.

"It seems from our experience in the various divisions of the court that the workers and the judge, the probation officer, and the physician should be guided in their work by a consideration of the emotional and nervous aspects of the life of the client even more perhaps than by the client's intellectual capacity. Another thing that seems to stand out is the small percentage of cases in which institutional commitment because of the mental condition is necessary.

"I think we shall find that the number of mentally sick people who can be handled by social workers and court officials even outside the walls of hospitals for mental disease will increase as we become less timorous and more scientific. But there are some people whom we have to commit, and I believe we should commit them in such a manner that they can be returned to normal life and sane human fellowship as soon as possible.

"There is one thing that I would like to emphasize, and that is that the court that has many people coming to it should have a staff of physicians, psychiatrists, and psychologists, and should have a social staff of trained workers. We no longer condemn a mentally sick man to an institution where there is no facility for scientific treatment and study. Therefore, by analogy, in the field of extra-mural work with the mentally afflicted, in the courts and elsewhere, we should also have an adequately trained personnel."

Mental Health Hints for Parents

The Mental Hygiene Committee of the Public Charities Association of Pennsylvania is publishing a series of leaflets entitled *Mental Health Hints for Parents,* for distribution at health centers and health-council meetings. The leaflets, which are written in very simple language and printed in clear, easily read type, contain suggestions as to some of the things that parents should do or should not do to insure the mental health of their children. The leaflets already published are I. *Before the Baby Comes,* II. *The Baby,* III. *The Toddler and Runabout,* and IV. *The Grade-school Years.* It is planned to extend the series to include the high-school years and the college years, and perhaps to get out a similar series on *Mental Health Hints for Teachers.*

The Individual As a Social Unit

Personally I hold—and I think every physician and especially every psychiatrist must hold—that the individual is not only the unit of the physician's interest, but also (following Herbert Spencer) the unit of the sociologist's interest. This we ought to maintain, I think, against the supposed sociological improvement introduced by Schaffle—namely, that the family is the social unit. Accordingly, I hold that the foundation of social psychiatry (as also of public psychiatry) is the psychiatry of the individual.

Josiah Royce made his contributions to the conception of the social consciousness in 1894-1895. From that atmosphere developed, in the work of Richard Cabot, the idea of medical social work. Mark you that this idea was far more than a mere addition of two ideas—namely, the idea of *medicine* and the idea of *social work*—but was a productive combination of these ideas, an actual novelty. It was then only a step to the development of psychiatric social work in Massachusetts, 1912, a step stated by Cabot himself (at the recent meeting of the National Conference of Social Work) to be the greatest innovation in medical social work since its foundation.

From Bakunin to Lenin is half a century. What has the world to say of anarchism and Bolshevism? Certainly these are no new things. Perhaps neither Bakunin nor Lenin is a topic for alienists of the old medico-legal group. These world leaders are not on the minute to be interned as insane! But does any man of us here believe that the psychiatric viewpoint could fail to throw light on Bakunin and on Lenin? Alone amongst the specialties of medicine, psychiatry has for its daily task the consideration of the entire individual. The rest of the branches of medicine, even neurology, appear to remain much too analytic in their view of a man. Psychiatry alone uses the daily logical apparatus of the synthesizer.

Is mental hygiene ready for the problem of Bakunin and Lenin? Alas, no! We have our *Varieties of Religious Experience,* but no James has arisen to depict, on the basis of the extremest cases, the varieties of political experience. In fact, the delineator of Lincoln or of Roosevelt as in any sense psychopathic might well bring down upon his head far more partisan fury than one who should discover the queerest traits and episodes in religious heroes. We deal with *Aqua Regia,* with Damascus blades, in our psychiatric laboratories and armories. " Divide to conquer " is a necessary precaution. We must teach the world what we as physicians have so recently learned—namely, that to be crazy is to be one of scores of things. To describe Lincoln as a cyclothymic with attacks of depression or Roosevelt as constitutionally hyperkinetic (always supposing these to be true designations) should be no more impolite or less objective than to think of Bakunin or Lenin as paranoic personalities. Crazy? No! But cyclothymic or paranoic, certainly!

Insanity is mental disease, but not all of it or rather all of them. Alienists are psychiatrists, but not all or in the long run the majority of psychiatrists. "Alienistics," as we may call the doctrine of medico-legal insanity, is not the whole of psychiatry. But, above all, psychiatry must be conceived to include the minor psychoses, the smallest diseases, and the minutest defects of mind as well as the frank psychoses and the obvious feeblemindednesses. The psychiatry of temperament is an art that might fling itself very far. Mr. Wilson, I believe, spoke of some members of his cabinet as " temperamental." As a cat may look at a king (time and weather permitting), so I suppose a psychiatrist might look at a cabinet officer, at least in one of his temperament phases.

We have passed from the age of Darwin to the age of Pasteur, to the age of Metchnikoff and of Ehrlich. We have lived through the beginning of systematic psychiatry in the period of Gresinger, we have witnessed the first clarification of mental disease function in the period of Charcot, and we have just concluded a war whose psychiatric achievements (from the deepest theoretical side) trace back to Charcot, flowering to my own mind in Babinski. In America, outside institutions, there has been a dearth of great theorists after Benjamin Rush. . . . The basic ideas of Weir Mitchell have been laid down and the work of Charles K. Mills stands out for me as of the greatest theoretical importance. . . .

But it is clear that the American idea mental hygiene must have grown in philosophical circles, too. I think first of the great Emersonian period, with its grotesque parody called Eddyism or Christian Science. Then I think of the laying-down of the idea of pragmatism by Charles Peirce, the great and little known central figure of Ameri-

can thought. And then I think of the man William James, who put pragmatism across the American scene, but added thereto what I may call the *psychiatric touch* and really typifies all that is best in American thought. Emerson, Peirce, James—these are three American names to conjure by, and they are deeply responsible for the spiritual, the logical, and the practical factors in the whole of mental hygiene. With their spirit, illumination, and dynamism, we shall face the terrible analyses of the present hour—the rights and interests of the individual as against society and of society as against the individual—with full confidence that synthesis will follow analysis and the task of Humpty-Dumpty be solved at last.

Do you not agree with me that in all the *pot-pourri* of the years this great problem of the place of the individual stands out? That American thought, transilluminated as always by the softened European lights, contains within itself immortal fundaments of the mental hygiene of nation, race, and person? And may we not rejoice, as psychiatrists, that we, if any, are to be equipped by education, training, and experience better than perhaps any other men to see through the apparent terrors of anarchism, of violence, of destructiveness, of paranoia—whether these tendencies are shown in capitalists or in labor leaders, in universities or in tenements, in Congress or under deserted culverts? It is in one sense all a matter of the One and the Many. Psychiatrists must carry their analytic powers, their ingrained optimism, and their tried strength of purpose into not merely the narrow circles of frank disease, but, like Seguin of old into education, like William James into the sphere of morals, like Isaac Ray into jurisprudence, and above all into economics and industry.—E. E. Southard, M. D., Presidential Address, American Medico-Psychological Association, 1919, *American Journal of Insanity.*

A Mental-Hygiene Committee in France

A committee on mental hygiene has been instituted by the Minister of Hygiene, Assistance, and Social Providence of France. The committee is composed of about forty members—alienists, psychologists, physiologists, managers, and magistrates. Dr. Dron, Senator and Mayor of Tourcoing, is its chairman. This committee has instructions to make a study of all questions relating to mental hygiene, psychiatry, and applied psycho-physiology in connection with the various social activities. It will study particularly methods of coördinating the efforts of the organizations at work in this field, of instigating and encouraging new lines of endeavor, and of disseminating information and advice on the subject of mental hygiene; in short, it will seek to determine the most effective medical and social methods of organiz-

ing the prophylaxis and treatment of mental diseases. Methods of testing the aptitudes of school children and of workers who have to do with public safety will be one of the subjects studied.

The Canadian National Committee for Mental Hygiene

The work of the Canadian National Committee for Mental Hygiene grows apace, and before long practically every province in Canada will avail itself of the services of their experts. Alberta, New Brunswick, and Nova Scotia have all asked for surveys of their provinces with the idea of bettering conditions in connection with the insane and mental defectives. Quebec and Ontario should fall in line in due course, as recent developments have shown that a great deal of constructive work should be done in these provinces. British Columbia and Manitoba have not only had surveys made, but have adopted the suggestions of the committee very extensively.—*The Toronto Globe.*

The Influence of the War Upon Syphilis of the Offspring

The Vienna correspondent of *The Lancet* (London) discusses the protracted and exhaustive series of investigations conducted by Dr. Hochsinger on the fate of the offspring of syphilitic parents during the war. According to the correspondent, all the records from 1911 to 1918 of babies born in the public hospitals of the former Austrian Empire, as well as, after the revolution, those of the present Austrian Republic, were taken into the investigation—a number amounting to 123,284. It appears that, while before 1914 the average percentage of clearly syphilitic offspring was 2½ per cent of all cases of birth, during the war the figure fell to 1.64 per cent of all births, a drop of 3.5 per cent. In the first years of life, signs of syphilis appeared in 1.82 per cent before 1914, but between 1914 and 1919 it was 1.25 per cent—that is, 30 per cent less. As regards the conditions in private families, it is a clear fact, says the correspondent, that the figures for before and during the war do not differ much; yet here, too, the last five years have shown an increase in the births of healthy children. The explanation of the latter fact is that in the better classes of the population a vigorous treatment of an acquired syphilis is the rule, and that permission to marry is generally not granted before repeated examinations have shown the patient to be free from infection. As regards the average man, nearly all men in the reproductive age were called to the army, and there every person suffering from fresh or old syphilis had every interest to report himself to the doctor; it meant for him freedom from actual service for weeks and months—often it liberated him totally. This fact produced a thorough treatment of, so

to say, all would-be syphilitic fathers. Now, however, the correspondent points out, there is nothing to enforce such general and effective treatment in cases of fresh infection, and unless legislation finds means to produce some similar measure of coercion, the beneficial results will soon be a thing of the past. The army has dispersed, compulsion of treatment no longer is aided by egotistic motives, and salvarsan is very expensive, too expensive for those people who need it most and will not go to a hospital.

The State and Mental Hygiene

There is just dawning in public consciousness the conviction that a governmental policy of inaction in mental hygiene is wasteful of public money as well as of human life and happiness; that mere adequate accommodation in buildings for the wreckage of mental disorders is poor business at the best; that self-interest and self-protection, if there be no higher plane of action, demand of the state aggressive search for causes of mental abnormality, their removal and prevention; that social service to mental patients in the community, in their homes, in social and industrial relationships, promotes early recognition, early treatment in the most curable stage, and oftentimes prevention of development or progress of mental and nervous disorders; that adequate community organization hastens discharge of such dependents from public institutions, safeguards and extends their home care, and prolongs self-support, delaying or averting their relapse and return to public dependence and minimizing the danger of increase of degeneracy in the future.—Owen Copp, M.D., The Duty of the State and the Physician to the Mental Patient, *The Pennsylvania Medical Journal.*

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MENTAL HYGIENE

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A CONSENSUS OF MEDICAL OPINION UPON QUESTIONS RELATING TO SEX EDUCATION AND VENEREAL DISEASE CAMPAIGNS

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IN the early summer of 1919, the United States Interdepartmental Social Hygiene Board made a grant of $6,600 to the Psychological Laboratory of the Johns Hopkins University for the purpose of assisting the laboratory in "investigating the informational and educative effect upon the public of certain motion-picture films used in various campaigns for the control, repression, and elimination of venereal diseases." At the time the grant was made, Dr. T. A. Storey, executive secretary of the board, suggested that the work should be carried out under the general supervision of an advisory board approved by the United States Interdepartmental Social Hygiene Board. Dr. Adolf Meyer, Dr. S. I. Franz, and Professor R. S. Woodworth have acted in such capacity throughout the work.

It seemed to the authors and to the advisory committee that before any experimental steps were taken in making the above investigation, it would be a distinct gain to obtain from medical men and women who have had most to do with problems in sex education and the actual treatment of venereal infections judgments and opinions as to what it is wise and safe to present to the public. In order to obtain these judgments, a questionary of very broad scope was prepared. This

questionary touched not alone upon questions dealing directly with campaigns against venereal disease, but also upon certain general questions of sex education.[1] The questionary was sent to all members of the American Psychopathological Association, the American Association of Genito-Urinary Surgeons, and the American Gynecological Society. Replies were received from the following:

American Psychopathological Association

Dr. E. Stanley Abbot
Dr. T. H. Ames
Dr. A. M. Barrett
Dr. A. A. Brill
Dr. Helen W. Brown
Dr. Sanger Brown, II
Dr. C. D. Camp
Dr. I. H. Coriat
Dr. H. W. Frink
Dr. H. I. Gosline
Dr. William W. Graves
Dr. T. H. Haines
Dr. R. W. Hall
Dr. G. Stanley Hall
Dr. R. C. Hamill
Dr. Arthur Hamilton
Dr. G. V. Hamilton
Dr. William Healy
Dr. J. Ramsay Hunt
Dr. S. E. Jelliffe
Dr. Ernest Jones
Dr. John T. MacCurdy
Dr. H. W. Mitchell
Dr. Abraham Myerson
Dr. Samuel T. Orton
Dr. Charles Ricksher
Dr. A. H. Ruggles
Dr. S. I. Schwab
Dr. H. D. Singer
Dr. H. C. Solomon
Dr. A. W. Stearns
Dr. Edward W. Taylor
Dr. J. S. Vanteslaar
Dr. R. M. Van Wart
Dr. F. L. Wells
Dr. W. A. White
Dr. C. C. Wholey
Dr. T. A. Williams
Dr. G. A. Young

American Association of Genito-Urinary Surgeons

Dr. Horace Binney
Dr. R. C. Bryan
Dr. Hugh Cabot
Dr. J. B. Clark
Dr. A. H. Crosbie
Dr. J. H. Cunningham
Dr. F. E. Gardner
Dr. J. A. Gardner
Dr. H. S. Kretschmer
Dr. W. E. Lower
Dr. W. C. Quinby
Dr. E. H. Siter
Dr. G. G. Smith
Dr. A. R. Stevens
Dr. John H. Stokes
Dr. G. K. Swinburne
Dr. G. S. Whiteside
Dr. A. C. Wood

[1] While our primary object in this investigation was to get judgments that would bear directly upon the question as to whether certain motion-picture venereal-disease campaigns are serving useful purposes, it is obvious to every one that the construction and evaluation of a film cannot be considered apart from the broader question of sex education. Parts I and II of our questionary deal with the general problems of sex education; part III deals directly with those factors which are of chief importance in venereal-disease campaigns.

American Gynecological Society

Dr. F. L. Adair
Dr. J. M. Baldy
Dr. L. H. Bernd
Dr. H. T. Byford
Dr. Hugo Ehrensfest
Dr. Ella B. Everitt
Dr. R. R. Huggins
Dr. J. C. Litzenberg
Dr. W. P. Manton
Dr. Jeanette H. Sherman
Dr. H. C. Taylor
Dr. J. W. Williams

Since the response to this questionary was so generous and since so many valuable judgments and opinions were formulated, we have thought it worth while to summarize the material so collected under each division of the questionary. The answers present so many divergent points of view that it has not been possible to classify them rigidly. The view of the majority is given in our summary under each question, and in addition we have quoted various divergent opinions that seem representative.[1] In general we have tried to present one or two opinions on the affirmative side of the question, followed by quotations that answer the question affirmatively, but with certain reservations, and finally by quotations that answer the question in the negative. At the end of these summaries we have tried to bring together the bearing of the questionary as a whole upon the scientific problems of the preparation of moving-picture films, propaganda against venereal disease, etc.

In the summaries under each question, group A embraces all replies of the members of the American Psychopathological Association; group B embraces those of the American Association of Genito-Urinary Surgeons and the American Gynecological Society.[2]

The first problem is to determine the consensus of medical opinion as to the amount and kinds of information concerning normal sexual processes that should be included in a pro-

[1] The complete replies are unquestionably worth preserving. For this reason we have prepared complete copies of all replies, representing about two hundred pages of typewritten material. These copies have been deposited as follows: United States Interdepartmental Social Hygiene Board, Washington; American Social Hygiene Association, Inc., New York; National Committee for Mental Hygiene, Inc., New York; Phipps Psychiatric Clinic, Baltimore; Boston Psychopathic Hospital, Boston.

[2] In giving replies, only those received from the medical men of the American Psychopathological Association were used. The replies of members of the advisory committee were likewise omitted.

gram of education for average adults to protect them from venereal infections and from maladjustments in marriage. It should be borne in mind that the great majority who are to be instructed lack a complete high-school education.

I. With Respect to Sex Instruction of Adults

1. Should information given to men and women differ? If so, in what respects? (At least one recent book advocates instruction for boys at puberty, but no instruction for girls until marriage.)

There were no unqualified affirmative replies in either group A or B, specifying completely different sex training for men and women.

In group A, 15 gave affirmative answers with qualifications. In group B, 13 gave similar answers. Samples of answers with qualifications are as follows:

> Dr. Helen W. Brown: "Information for men and women should differ chiefly in that men should be instructed more in male physiology and women in female. In sociology they should be given the same body of facts."
>
> Dr. G. V. Hamilton: "Yes. Less explicit information to girls until just before marriage; but both girls and boys ought to know the essential facts of reproduction long before puberty."
>
> Dr. Abraham Myerson: "Information given to men and women should differ. Men should receive more instruction in venereal disease and the dangers of prostitution; women more instruction on birth and its relationship to intercourse. Every boy should be taught at puberty, but not every girl. Individual differences would have to be kept in mind."
>
> Dr. S. I. Schwab: "Yes. In girls the physiology of menstruation is the most outstanding fact. In boys the physiological aspect is of less consequence."

In group A, 21 physicians gave negative answers without qualifications to the effect that instruction for men and women should not differ. In group B, 17 such answers were returned. Types of negative answers are as follows:

> Dr. A. A. Brill: "No, they should be given the same information. They should be told everything."

Dr. R. W. Hall: "No, there is too little knowledge and appreciation of the problems of the opposite sex as it is."

Dr. S. E. Jelliffe: "I do not believe different instruction desirable."

In many of the affirmative answers with qualifications, one qualification consisted in a recommendation that there should be a difference in instruction for young boys and girls. When instruction for adults is considered, their answers should be grouped with the unqualifiedly negative answers.

In general all of the contributors agreed that such instruction is desirable and should be given to both men and women and that instruction should start at an early age. In at least two instances, however, statements were made to the effect that no instruction should be given to girls until marriage.

2. Should the anatomy and physiology of the individual's own sex organs be taught? . . . If so, should the instruction aim to give details or to include only such facts as come directly within the individual's experience—erection and ejaculation in men, menstruation in women?

In group A, 18 replied that the anatomy and physiology of the individual's own sex organs should be taught with all possible detail. In group B, 14 gave affirmative answers. Types of such answers are as follows:

Dr. E. Stanley Abbot: "Yes. Instruction in anatomy and physiology of reproduction should be given with about the same amount of detail as that of circulation, digestion, etc. This would include more than comes within the individual's experience."

Dr. Sanger Brown, II: "I would approve giving detailed instruction, but in such a way as to avoid morbid curiosity."

Dr. T. H. Haines: "Teach biologically the significance of the sexual act for race and individual. This makes anatomy and physiology necessary, but incidental to sex hygiene."

Dr. W. A. White: "I think enough should be taught so individuals can have an intelligent understanding of the function of these organs."

In group A, 14 agreed that anatomy and physiology of the individual's own sex organs should be taught, but without

detail, and that only such factors as come within the individual's own experience should be considered. In group B, 14 gave similar answers. Types of answers are as follows:

> Dr. I. H. Coriat: "Yes; the finer anatomical and physiological details may be omitted."
>
> Dr. Samuel T. Orton: "Only the facts of direct experience."
>
> Dr. R. M. Van Wart: "Yes; instruction should be limited to the necessary details."
>
> Dr. C. C. Wholey: "Yes. But only to the extent of giving a general, but common-sense understanding of the anatomy and functions, using comparative anatomy for illustrative purposes and human anatomy of the same sex as that of the audience being addressed. The material dealt with should not go beyond the facts coming within the individual's experience."

In group A, 3 replied that no instruction whatsoever should be given. In group B, 2 returned similar answers. Types of answers are as follows:

> Dr. C. D. Camp: "I see no reason for such instruction except to say that they are quite natural."
>
> Dr. A. W. Stearns: "No. See no reason for teaching sex anatomy more than that of heart or stomach. Do not believe sex should be featured."

3. Should the anatomy and physiology of the organs of the opposite sex be taught in the same detail?

In group A, 14 physicians answered unqualifiedly yes. In group B, 5 gave affirmative answers. Types of affirmative answers are as follows:

> Dr. T. H. Ames: "Yes. To children and to adults."
>
> Dr. H. W. Frink: "Yes. I consider this quite important. I often see patients, both males and females, who, having had until well into adolescence erroneous ideas of the anatomy of the opposite sex, had indulged for some years in masturbatic or other erotic fantasies of sex acts based on these erroneous conceptions. The result is that, in psychoanalytic language, a certain portion of the individual's libido is 'fixed' upon these fantasies which it is then difficult to transfer to normal sex aims when legitimate occasions for sex relations occur. Ignorance, in short, favors the formation of sexual aims which are either definitely perverse or at

least impossible of fulfilment in a normal sex life. This in turn forms marital dissatisfaction, or the development either of perversion or neurosis. Since adolescent and pre-adolescent sex desires must exist, and, if existing, they must have some goal, it is obviously better that such goals be normal ones."

Dr. R. W. Hall: "Yes. (For the reason under 1.) There is much curiosity concerning the opposite sex and this will be gratified somehow and may as well be accurate and controlled information."

Dr. Ernest Jones: "Yes."

Dr. J. S. Vanteslaar: "That is highly desirable, *on the part of the right instructor;* otherwise mischievous."

In group A, 10 gave affirmative answers with qualifications. In group B, 6 gave similar answers. Types of such answers are as follows:

Dr. T. H. Haines: "Only as necessary to give the proper biological and social perspective to personal hygiene."

Dr. H. C. Solomon: "I believe that the anatomy and physiology of the organs of the opposite sex should be taught in the same detail as that of the own sex, qualifying this remark again by the age limitation; that is, I do not believe that much detail about the opposite sex should be gone into before the adolescent period. I do not mean that it should be avoided, but it should not be made a matter of detailed explanation."

Dr. J. W. Williams: "The male should be instructed particularly in the anatomy and physiology of his organs, and only generally those of the female, and vice versa."

In group A, 13 gave an unqualified negative response. In group B, 18 opposed the teaching of the anatomy and physiology of the organs of the opposite sex in the same detail. In general the negative responses were left entirely unqualified. Types of answers are as follows:

Dr. J. M. Baldy: "No, it only excites curiosity and may readily be the final determining factor of the downfall."

Dr. Arthur Hamilton: "No."

Dr. C. C. Wholey: "No, it would serve no necessary purpose and its chief effect would be to arouse sexual desire."

It is quite evident from the answers of the group as a whole that in group A the affirmative and negative are about equally divided, but that in group B the negatives far preponderate.

4. Should details of ovulation, impregnation, and the development of the embryo be taught or should instruction be limited to the external manifestations of pregnancy and to personal hygiene?

In group A, 15 of the replies favored unlimited instruction in the details of ovulation, impregnation, etc. In group B, 8 gave unqualified support to the teaching of detail. Types of answers are as follows:

> Dr. T. H. Ames: "By all means the details of ovulation, impregnation, and the development of the embryo—as in botany and zoology."
>
> Dr. H. I. Gosline: "All should be taught. Not all will be grasped, I take it."
>
> Dr. H. W. Mitchell: "See no harm in teaching to the limit of opportunity and individual capacity."

In group A, 19 replied to the effect that instruction should be limited to the external manifestations of pregnancy and to personal hygiene. In group B, 20 spoke for limited instruction.

> Dr. A. A. Brill: "Instruction should be limited to the external manifestations, etc."
>
> Dr. Samuel T. Orton: "With the grade of intelligence indicated above, the details could hardly be properly presented."
>
> Dr. S. I. Schwab: "To pregnancy and hygiene."
>
> Dr. H. D. Singer: "Chiefly personal hygiene."

In group A, 2 maintained that no instruction of any kind should be given. In group B, 1 returned a similar answer.

> Dr. A. W. Stearns: "Both might do harm."

5. Should members of either or both sexes be instructed before marriage in the physiology and psychology of coitus? . . . If so, with what detail?

Answers to this question were somewhat complicated by reason of the fact that many who believe thoroughly in the complete instruction in the physiology and psychology of coitus differ somewhat as to when instruction should begin and as to whether it should be given to both men and women. The general sentiment seemed to be that such instruction should be gradually led up to, so that by the time of marriage both sexes would have complete information. Those answers which are marked affirmative, then, agree that such instruction should be given, but they would show differences as to the time at which such instruction should be given.

In group A, 18 gave an unqualified affirmative, whereas in group B, 7 gave similar answers.

> Dr. T. H. Ames: "Yes, both sexes should be instructed in complete detail, telling of the various possibilities of the experiences of a neophyte compared to the experienced person. Particularly should they be told that experience makes perfect."
>
> Dr. S. E. Jelliffe: "I believe so; in considerable detail."
>
> Dr. C. C. Wholey: "Adults only; both sexes chiefly along lines having to do with the psychology. The matter should be handled with a view to emphasizing the dignity and value and biological place of sexual relations; it should aim to break down morbid and unnatural fears which have grown up out of religious bias or by reason of impressions instilled through hysterical individuals. It should, also, aim to evaluate sexual relations properly, so that the individual will discontinue making this the primary aim of his or her existence and appreciate the dangers to married life of seeing nothing beyond sexual gratification."
>
> Dr. G. A. Young: "Yes. To the end that normal orgasms should be attained by both parties."

In group A, there were 10 affirmative answers with reservations, whereas in group B, there were 12.

> Dr. W. P. Manton: "Questionable. Young men are usually informed; young women are often ignorant, and in many instances benefit would result if they could be informed what to expect."
>
> Dr. Abraham Myerson: "Just before marriage members of both sexes should be instructed in the physiology and psychology of coitus. Details should be given to the man, general aspects of the situation to the woman."
>
> Dr. E. H. Siter: "Necessary for the female."

Dr. G. S. Whiteside: "Yes, especially men. Details should be explicit. Many men shock women through clumsiness and ignorance."

In group A there were 4 completely negative answers; in group B, 10.

Dr. T. H. Haines: "No. Embryology is sufficient. The psychology of the unexperienced can be of no service in control."

Dr. J. M. Baldy: "No, only excites curiosity. Can see no possible good to offset that fact."

Dr. Hugh Cabot: "Such teaching is highly risky business, and I am unwilling to assent to it at present."

Dr. Charles Ricksher: "I can see no special reason why they should be."

Dr. Jeanette H. Sherman: "No."

Several physicians answered frankly: "I do not know."

6. How frequent, in your experience, are cases of maladjustment in marriage relations because of the husband's ignorance of sexual processes in women?

In group A, 14 gave unqualified assent that maladjustments from such a cause are frequent. In group B, 11 gave similar answers.

Dr. T. H. Ames: "Very frequent. Many men married twenty years never knew women have orgasms and never try to give their wives satisfaction, thinking only of themselves."

Dr. Hugh Cabot: "Very common."

Dr. G. V. Hamilton: "So frequent as to constitute a serious problem in hygiene."

Dr. J. C. Litzenberg: "Very many—a large percentage."

Dr. E. H. Siter: "Eighty per cent."

Dr. J. S. Vanteslaar: "This is one of the most common causes of maladjustment and one of the most prolific sources of morbidity in both sexes."

In group A, 5 gave an affirmative answer with certain reservations. In group B, there was only 1 such answer.

Dr. E. Stanley Abbot: "I have no data. It seems to me inevitable that other factors than this special ignorance would enter into the causation of maladjustment in this field, and their relative values would be difficult to determine. I had one case in which there was not maladjustment in marriage relations, in which the husband did not know when or whether his wife was menstruating."

Dr. J. Ramsay Hunt: "Impossible to say. In my opinion it is not so much a question of ignorance as lack of instinct and interest. In other cases it is a serious disorder requiring appropriate treatment."

In group A, 9 replied with an unqualified negative or with the statement that it was extremely rare. In group B, 14 returned similar answers.

Dr. L. H. Bernd: "Have seen but one case."

Dr. Horace Binney: "Never."

Dr. I. H. Coriat: "Very rare."

Dr. T. H. Haines: "Do not know of any such."

Dr. Jeanette H. Sherman: "Infrequent."

Dr. A. W. Stearns: "Rarely and only in psychopaths."

Dr. J. W. Williams: "Very rarely."

7. Is this sufficient to justify a demand for instruction of young men in the psychology of sex?

In group A, 16 returned unqualified affirmative answers; in group B, 10.

Dr. J. M. Baldy: "I think this is one of the important points of teaching on these subjects."

Dr. Hugh Cabot: "I have no doubt that satisfactory personal instruction in the psychology of sex before contemplated marriage would save much maladjustment."

Dr. G. V. Hamilton: "Yes, but instruction must not be entrusted to other than well-trained psychologists."

Dr. J. S. Vanteslaar: "The demand for such instruction is one of the most acute needs of civilization. I doubt whether the proper technique for the work has been established. I know that the right kind of instructors are extremely rare."

In group A, there were 7 affirmations with reservations; in group B, 2.

Dr. F. E. Gardner: "Yes, with marriage in view, but not otherwise."

Dr. R. M. Van Wart: "There is as a rule not a sufficient number of cases of this character to justify details. Instruction in most cases of this character has occurred in individuals who are otherwise than psychopathic."

Dr. G. S. Whiteside: "Yes, but not in the perverted mode of the degenerate. Normal sex psychology is best."

In group A, there were 10 negative replies; in group B, 15.

Dr. F. L. Adair: "I think not."

Dr. J. H. Cunningham: "No."

Dr. J. Ramsay Hunt: "No, those who need such instruction usually require intensive individual treatment and would not benefit by public lectures or instruction in this matter."

8. How frequent, in your experience, are cases of serious emotional shock at first coitus in women?

In group A, 5 affirmative answers were returned; in group B, 2.

Dr. A. M. Barrett: "They are rather frequent."

Dr. Hugh Cabot: "I think them common."

Dr. Ernest Jones: "Very."

Dr. J. T. MacCurdy: "I believe it extremely frequent."

Dr. J. S. Vanteslaar: "They are very frequent and owe their serious nature to the fact that they are part and parcel of an unhealthy attitude of mind which can be corrected only by judicious, careful, long-continued instruction and educational readjustment to the whole matter of sex."

In group A, there were 4 affirmative answers with reservations; in group B, 4.

Dr. A. A. Brill: "Not very frequent, unless both are ignorant, but it is not unusual."

Dr. J. C. Litzenberg: "Not many, but have known of several."

In groups A and B, there is an overwhelming agreement that shock at first coitus is rare. In group A, 22 of the answers stated that shock either never occurs or occurs very rarely. In B, 22 returned the same reply.

Dr. Helen W. Brown: "Not very frequent."

Dr. Samuel T. Orton: "Practically only in prudes and other neuropathics."

Dr. A. H. Ruggles: "Very infrequent."

Dr. S. I. Schwab: "I have never seen such a case."

Dr. J. W. Williams: "Extremely rare if the man has decent instincts."

9. Do you find that sexual anæsthesia is frequently ascribable to this cause?

In group A, 4 replies stated without qualification that sexual anæsthesia in women is frequently the result of emotional shock at first coitus. In group B, there were only 2 affirmative replies.

Dr. T. H. Ames: "Yes, the woman 'holds back' from what is disagreeable."

Dr. A. M. Barrett: "Yes."

Dr. Sanger Brown, II: "Sexual anæsthesia is very complex psychologically, but may be caused in this way."

Dr. Hugh Cabot: "Yes, though full sexual anæsthesia is a slow development."

In group A, 10 affirmative replies with reservations were received. In group B, 4 returned similar replies.

Dr. A. A. Brill: "Yes, but as a rule it is more fundamental; most cultured women are more or less anæsthetic during the first period of married life."

Dr. S. E. Jelliffe: "It is said so, but close inquiry usually reveals other affective situations as the underlying cause."

Dr. J. C. Litzenberg: "Sometimes."

Dr. Samuel T. Orton: "Only in neuropathics."

Dr. W. A. White: "Probably only partially."

As in the preceding question, negations outweighed all affirmations. In group A, 14 replied with unqualified negatives, and in group B, 14 returned negative answers.

Dr. Ella B. Everitt: "No."

Dr. J. T. MacCurdy: "I would rather not say that sexual anæsthesia is ascribable to this cause, but rather that the shock and the subsequent anæsthesia are both the result of a preëxistent abnormality."

Dr. G. S. Whiteside: "No. I believe sexual anæsthesia due to lack of preliminary stimulation."

Dr. C. C. Wholey: "No, not unless some anomalous psychic condition has previously existed."

There are 10 physicians who state frankly that they "do not know," they "have never investigated," or that their "facts do not warrant an opinion."

10. How frequently is maladjustment the result of the woman's belief in the obscenity of all sex relations?

In group A, 8 replied that it was frequently ascribable to this cause. In group B, 8 returned similar answers.

Dr. H. T. Byford: "Quite frequently."

Dr. J. Ramsay Hunt: "Quite frequently; because of her lack of interest and lack of instinct—and from a neurotic constitution and bad environment, where all joy and pleasure are regarded as sinful."

Dr. S. E. Jelliffe: "About 25 per cent of some thousand cases inquired into. Higher percentages among the so-called upper classes and religious people."

Dr. Ernest Jones: "Always."

Dr. E. H. Siter: "Seventy-five per cent."

Dr. J. H. Stokes: "Thirty per cent."

Dr. T. A. Williams: "Quite frequent."

In group A, there were 6 qualified affirmatives; in group B, 5.

Dr. Hugo Ehrensfest: "I feel that this is entirely dependent upon the religious instruction received since puberty; while probably not often causing maladjustment, the feeling of the obscenity of coitus is not rare."

Dr. W. E. Lower: "Believe it is only a small class that has this belief."

Dr. J. T. McCurdy: "I believe that the obscenity of sex is certainly a factor in this situation, but I believe that it is more of a rationalization than a primary cause."

In group A, 15 replied unqualifiedly in the negative, and in group B, 15 returned negative answers.

Dr. W. W. Graves: "The average or so-called normal woman could not entertain such belief. To entertain such ideas in connection with the primitive maternal (sexual) instinct is strongly presumptive evidence of abnormality."

Dr. R. W. Hall: "Infrequent. Women have a surprising 'matter-of-fact' attitude. Most of the cases that I recall who developed neurosis to avoid intercourse had other reasons than obscenity."

Dr. W. C. Quinby: "Rarely. Such belief, though not very rarely advanced as a cause, is not often *honest*—i. e., often a woman giving this belief as a cause of maladjustment is *lying.*"

Dr. A. C. Wood: "Have met but one case."

Dr. J. W. Williams: "Very rare, as far as I know. I have only seen two such cases."

11. Do these conditions justify a demand for instruction concerning coitus for women before marriage? . . . If so, at what age should it be given?

In summarizing this question, we shall discuss the second part of it—the age at which sex instruction should be given—separately below. In regard to the first part, it was found that in group A, 25 returned positive answers to the effect that these conditions justify a demand for instruction concerning coitus for women before marriage; group B returned 12 positive answers.

Dr. A. H. Crosbie: "Just before marriage."

Dr. J. A. Gardner: "Yes; twenty years."

Dr. R. C. Hamill: "Yes; when asked for. If it can be given early, it may never be regarded as improper knowledge."

Dr. Ernest Jones: "Yes; as early as possible."

Dr. J. C. Litzenberg: "Yes! Not too early."

Dr. A. H. Ruggles: "Yes; just previous to marriage."

Dr. G. G. Smith: "Yes; immediately before marriage."

Dr. W. A. White: "Yes; during adolescence."

In group A, 4 returned reserved affirmations. In group B, 8 replied affirmatively with certain qualifications.

Dr. F. E. Gardner: "It is desirable for women to receive such instruction before marriage, but only when the latter is intended."

Dr. H. I. Gosline: "Opportunity should be given. A 'demand' is too strong. When the woman wants to know. It is an individual matter."

Dr. W. P. Manton: "To a limited degree. Just before marriage."

Dr. J. S. Vanteslaar: "Theoretically, yes; a practical difficulty is to find teachers possessing the right tact, knowledge, and inspiration for the task."

In group A, there were 7 negative replies; in group B, 9.

Dr. J. M. Baldy: "No. Not at all, unless by the mother."

Dr. C. D. Camp: "No. The difficulty arises from improper education, not lack of it."

Dr. J. H. Cunningham: "No."

As far as the age is concerned at which such instruction should be given, the distribution of answers is as follows: 7 stated that instruction should be given when and as curiosity begins to manifest itself; 11 stated that instruction should begin at puberty or at the close of puberty; 21 stated that instruction should be given just prior to marriage. In this group are included those who stated that information should be given just before engagement or when marriage age is reached. It is interesting to note that 13 of those who returned this latter answer belonged to group B.

12. What methods do you use in dealing with such maladjustments and with what success?

The replies to question 12 were of such a character that it seems best to quote freely various types of answers rather than to attempt any analysis. The following replies were all taken from group A. The replies returned by group B showed quite clearly that they are not used to dealing with such problems. This is easily understandable in view of the fact that their primary interest is in surgery.

Selected Types of Reply

Dr. T. H. Ames: "Methods combining instruction in anatomy, physiology, psychological reactions, and psychoanalysis. Success depends upon the patient's intelligence and desire to overcome the difficulty. Some people do not care either to improve or to give satisfaction to their mate."

Dr. A. A. Brill: "In intelligent cases, I always resort to analysis with excellent success."

Dr. C. D. Camp: "Find the source of the wrong impression and reëducate. If the source can be found, success is frequent."

Dr. I. H. Coriat: "A rational explanation based upon the psychoanalytic conception of the sexual emotions and cravings."

Dr. H. W. Frink: "Most of the cases of maladjustment that I am called upon to deal with are serious ones, and I use the method of psychoanalysis, with good success generally. In many cases, a few frank talks with one or both parties is sufficient.

"I have recently come across a book called *Sane Sex Life and Sane Sex Living,* by Dr. H. W. Long, which I have given to certain couples, and they derived great benefit from reading it. Unfortunately the book has several glaring faults—e. g., misstatements as to sex physiology, an ill-considered recommendation of *coitus reservatus,* etc.—but it is the only work I happen to know of that is at all likely to teach ignorant and inhibited people the proper spirit of the sex relations or give them any real insight into the *ars amandi.* A book written in somewhat the spirit of this one, but by a person having a little sounder knowledge of the physiological and psychological factors involved, would be a very valuable instrument in dealing with many milder sorts of maladjustment. I do not feel very much in favor of such a book being made accessible to the unmarried, however."

Dr. W. W. Graves: "Education in matters of sex is the foundation of treatment, but each case presents its own problems; hence details cannot be given."

Dr. R. W. Hall: "It is largely a matter of leading the patient to face the situation frankly. The big majority of these cases are cleared up—or at least patched up. For an estimate of the patient's assets and make-up goes hand in hand with a facing of the situation, and constitutional traits are not easily altered. But if there is insight into them, there is just so much gained and future readjustment must take these things into consideration—just as a cripple regards his wooden leg. Still he walks."

Dr. R. C. Hamill: "Attempt to get the patients to tell themselves, in my presence, what the cause of the maladjustment is; then try to show them how they came to take their personal slants toward the matter, and how as towards a normal reflex action, such a slant is unjustifiable."

Dr. Arthur Hamilton: "Endeavor to explain the physiology of the situation to both parties. But such harm as develops has often already appeared, and it is difficult to undo the situation which has developed."

Dr. C. V. Hamilton: "Husband and wife are talked to separately. Husband is told how to excite his wife's sexual desire each time copulation is attempted; wife is told how to avoid undesirable pregnancy without injury, and how to insure occurrence of her orgasm and her husband's at the same moment. I have had better luck with this than with any other psychotherapeutic problem."

Dr. S. E. Jelliffe: "Much depends on the nature of the maladjustment;

(1) Anxiety-neurosis type—need only straight instruction—finding out chief obstacles.
(2) Compulsion cases—severe maladjustments are helped by psychoanalysis.
(3) Some cases need divorce—but rarely (impotent husbands often, homoerotics chiefly.)"

Dr. Ernest Jones: "Psychoanalysis, with good success. But tedious and painful."

Dr. J. T. MacCurdy: "My experience is not large enough to justify generalizations as to the value of different methods. It is my opinion, however, that the only radical treatment of these maladjustments is a historical understanding of the conditions, which can be obtained only through rather vigorous individual analysis. The minor difficulties which depend merely on ignorance and misinformation may be met effectually by belated education."

Dr. Abraham Myerson: "Methods used involve a conference with both the man and the woman involved, separately and together; clear-cut explanation of the origin and symptoms, and the attempt to remove prudery, fear, and roughness."

Dr. Samuel T. Orton: "Simple explanation of the normality of the processes and their place in the natural phenomena of both animal and plant world. In intellectual individuals is usually good except in long-standing cases and serious neuropathic disturbances."

Dr. A. H. Ruggles: "A straightforward talk concerning this subject, with a simple, straightforward explanation of it as a normal act."

Dr. Edward W. Taylor: "Analytical. Considerable success. The outlook is encouraging."

Dr. R. M. Van Wart: "The proper explanatory education of individuals with a rational viewpoint has in most instances led to a correction of the maladjustment."

Dr. W. A. White: "By psychoanalysis which uncovers the determiners."

Dr. C. C. Wholey: "Plain statements of fact, differing with type of individual being treated—methods of approach differing as widely as the types of individuals differ."

13. In your opinion, will a widespread knowledge in the unmarried of the physiology of sex lead to an increase in sex offenses?

In group A, 6 physicians indicated unqualifiedly their belief that a widespread knowledge of the physiology of sex would lead to an increase in the number of sex offenses. In group B, 9 returned similar replies.

Dr. H. S. Kretschmer: "Without any shadow of a doubt."

Dr. W. P. Manton: "Very apt to, especially in instance of young men, who like to 'prove all things.'"

Dr. Abraham Myerson: "I believe that a widespread knowledge in the unmarried of the physiology of sex will lead to an increase in sex offenses. I do not think that on the whole information tends towards protection."

In group A, 9 returned answers with reservations. In group B, 10 returned similar answers. The types of answers quoted will make clear the general nature of these reservations.

Dr. C. D. Camp: "Complete knowledge would not, but anything short of that would be likely to do so."

Dr. J. B. Clark: "A broad knowledge will not upset a broader mind; but a little knowledge is a dangerous thing."

Dr. H. W. Frink: "May increase the frequency of premarital intercourse, though probable not seriously. Will decrease the frequency of post-marital illicit intercourse, and of the offenses resulting from perverse sex impulses."

Dr. Arthur Hamilton: "Probably it will, but this is not sufficient to overbalance the propriety of the instruction."

Dr. J. W. Williams: "Yes, in the very young. No, in more mature individuals."

The majority of physicians in both groups stated unqualifiedly that such knowledge will not increase sex offenses. In group A, 21 returned answers to this effect; in group B, 17.

Dr. I. H. Coriat: "No, not if properly taught by competent persons."

Dr. S. E. Jelliffe: "No, quite the reverse."

Dr. J. C. Litzenberg: "No, if such education is accompanied by a moral, ethical, and religious side of the question."

Dr. G. K. Swinburne: "I do not believe so, but more likely to have the opposite effect if properly carried out."

14. What causes of illicit intercourse in adults have impressed you as most important?

In view of the importance of the question and the varied types of answers that were returned, it seems best to quote again rather freely rather than to attempt an analysis.

Replies from Group A

Dr. E. Stanley Abbot: "Self-indulgence; strong sex desire; superstition that it is necessary for health; that one must 'prove his manhood;' examples, teaching, and the taunts of companions; desire for experience; thoughtlessness and ignorance."

Dr. T. H. Ames: "1. Sexual desire. 2. Belief that intercourse is the thing that 'everybody is doing.' 3. Determination to do the forbidden thing."

Dr. A. M. Barrett: "Lack of consideration for the position of women. A feeling that intercourse is necessary for health."

Dr. Sanger Brown, II: "The power of the sex instinct in itself is the main cause."

Dr. C. D. Camp: "Boredom, enticement by the opposite sex."

Dr. I. H. Coriat: "Inability to properly sublimate the sexual craving."

Dr. H. W. Frink: "Within the particular sphere of my direct observation (which is pretty well limited to people of more or less culture, education, and intelligence) the commonest cause of illicit intercourse in adult males, whether married or unmarried, is undoubtedly that peculiarity of object-choice which Freud has discussed in his two papers on the psychology of the love-life. This peculiarity, which in very typical cases may be known as *Dirnenliebe*, consists in the fact that the man *prefers* as a sex partner the woman who has something of the *courtesan* about her, who is not too 'pure,' who is not his social equal, and whom he does not have to respect. Only with such a woman do sex desires and physical sex enjoyment, in a man of this type, reach their highest point, while with the 'pure' woman—the wife, for example—the physical sex feelings are inhibited in varying degrees, extending on the one hand from merely imperfect enjoyment of the sex relations to actual psychic impotence with the legitimate partner, on the other.

"The corresponding peculiarity of object-choice in the female is a real, though not nearly so frequent, cause of women's seeking illicit relations. Much more commonly, illicit relations in the case of married women are secondary to the fact that the husband belongs to the type above referred to and consequently does not or cannot assume the attitude that would bring out a normal sexual response in the wife. She then at length falls a prey to some man who can take a loverlike attitude toward her and give her a taste of real sexual courtship.

"I consider this peculiarity of object-choice in the male particularly important from the point of view of sexual education, for its development is by no means inevitable and may, I believe, be easily prevented by proper education in childhood.

"How common this sort of 'fixation' is among the lower classes I do not know, but I imagine that with them it is less common and less important than with the educated, while, on the other hand, the economic factors and mental defects increase in importance as causes of illicit intercourse."

Dr. H. I. Gosline: "The unmarried state. The causes of this are as diverse as the personalities and the environments involved."

Dr. W. W. Graves: "1. The sexual instinct. 2. Psychopathic personality. 3. Feeblemindedness. 4. Evil associations. 5. Economic conditions. 6. Alcoholism."

Dr. T. H. Haines: "The widespread belief that the male must have intercourse to be healthful. Alcohol is secondary."

Dr. R. W. Hall: "1. Propinquity. 2. As I recall the A. E. F. venereal statistics (Ashburn), one-third of the group had no intercourse in France, one-third very infrequently, and one-third when opportunity occurred. Whatever rôle alcohol played here before the war, it was a factor in a surprisingly low percentage of infections in the A. E. F. Houses of prostitution are of course a big factor everywhere (where they exist). To the average man a stimulating setting precedes a need. Among the married the man's getting 'fed up' with the marital situation is obviously the most frequent cause. If there were a bigger element of the chase after marriage, there would be less jumping over the traces. Among the unmarried, postponement of a marital state till economic factors permit is of considerable importance. But the main thing after all is the woman's attitude, especially in the face of pressure."

Dr. R. C. Hamill: "The frigidity of women, the curiosity of men."

Dr. Arthur Hamilton: "Too close association of the sexes with no supervision."

Dr. G. V. Hamilton: "Lack of decent ideals embodied in an affective and intellectually acceptable formulation of religious belief; economic obstacles in the way of early marriage; failure of husbands to seduce wives and consequent sexual indifference of wives; wives' fear of pregnancy; uncongenial relations between spouses."

Dr. S. E. Jelliffe: "1. Selfishness of men who want something for nothing. 2. Ignorance of consequences. 3. Promises of marriage. 4. Vanity and love of finery among women."

Dr. Ernest Jones: "Presence of sexual instinct."

Dr. J. T. MacCurdy: "Apart from the fundamental importance of the sex instinct itself, I believe the most important causes are to be found in the real rather than in the assumed attitude of society. Even in this country the practical standards of so-called morality vary tremendously in reference to the conduct of both sexes."

Dr. H. W. Mitchell: "Tolerance of the 'double standard.' Inability to provide homes and commercialized prostitution, for men. Poverty, inability to secure luxuries desired, strong sex appetite and alcoholic indulgence, for women."

Dr. Abraham Myerson: "1. Alcoholism. 2. Association in business, as for example the employer and the employed, master and maidservant. 3. Desire for luxuries and luxurious pleasures (a good time, theater, cabaret, etc.) 4. Uniforms. 5. Incompatability and dissatisfaction with the mate; absence or sickness of the wife

or husband. 6. Desire to break away from the monotony finds its chief outlet in sex excitement, flirting, dancing, etc.; modern dress and the prevalance of sex themes in the movies and theaters and the prominence of sex crimes in the papers tend to emphasize the situation. 7. The main cause, of course, is the polyvalent sex feeling rarely satisfied by marriage, constantly inhibited and constantly breaking through the restraint. It is perhaps cynical to say this, but nevertheless true that the majority of continent adults are such through fear, prudery, or lack of opportunity.''

Dr. S. I. Schwab: ''1. Accidental meetings. 2. Alcohol. 3. Mental conflicts. 4. Medical advice to men. 5. Adventure and imitation. 6. Sexual desire awakened by 'rotten' books, pictures, plays, etc.''

Dr. H. C. Solomon: ''The most important factor, I believe, is that of the environmental condition under which one is living; in other words, the ethical and moral ideals of the group with which one associates.''

Dr. Edward W. Taylor: ''Late marriage, economic conditions, drink, lack of knowledge, bad associates.''

Dr. R. M. Van Wart: ''Individuals in whom the desire is difficult to control.''

Dr. W. A. White: ''The causes are probably multitudinous, of which feeblemindedness among women is the most prolific source of prostitution.''

Dr. C. C. Wholey: ''Bachelorhood in man; of less importance in women. Incompatibility in the married, arising largely from hasty marriages where the all-dominating influence of sex blinds the individuals to the common considerations of the more permanent foundations of congeniality and happy partnership. Greater laxity in social attitude toward sexual transgressions and greater security in women being able to avoid conception; also the stimulus, given in recent years through much of the popular literature, in the direction of its being their privilege to know life more fully through sexual indulgence.''

Dr. G. A. Young: ''Lack of home training in sex matters.''

Replies from Group B

Dr. F. L. Adair: ''Wife's fear of becoming pregnant. Overeating and over-drinking. Idleness.''

Dr. J. M. Baldy: ''The constant sexual impulse in the man—and the opportunity of close intimacy with the female—aided by the modern drinking, smoking, and undress of the female. In the woman, who can tell but the woman herself?''

Dr. L. H. Bernd: "Alcohol, lack of exercise, lack of mental occupation."

Dr. R. C. Bryan: "Marital infelicity."

Dr. H. T. Byford: "Ignorance of the dangers, and erroneous belief that nature requires it. Example."

Dr. Hugh Cabot: "In the male, imperious sex. In the female, curiosity, misapprehension of consequences."

Dr. J. B. Clark: "The difficulties placed in the way of early marriage and home-building by our modern industrial and social conditions and by the lack of sound *early* training."

Dr. Hugo Ehrensfest: "Alcohol, the most important."

Dr. Ella B. Everitt: "Ignorance on the part of both sexes. Lack of moral principles."

Dr. F. E. Gardner: "In married people, maladjustment; ignorance on the part of the husband how to remedy it, or unwillingness on his part to take the trouble, coupled with apathy on the wife's part."

Dr. J. A. Gardner: "Late marriage and high cost of living."

Dr. J. C. Litzenberg: "Double standard of morals in case of men. Lack of protection in case of women. By protection I mean family protection and protection which guards against promiscuous mixing of sexes and 'chaperonage.'"

Dr. W. P. Manton: "Eros, Pothus, Himerus. The theater, suggestive pictures, literature, alcohol, often ennui and propinquity."

Dr. W. C. Quinby: "Lack of education on such subjects. Lack of development of power of inhibition."

Dr. Jeanette H. Sherman: "Money—lack of money among lower classes of girls."

Dr. E. H. Siter: "Lack of sympathy and reciprocity and difference in sexual temperament in the married. The animal in the unmarried males and females. Financial considerations in the latter sex."

Dr. G. G. Smith: "1. Alcohol. 2. Sexual desire (a) plus a belief that the other party was 'safe,' (b) regardless of everything except the desire for intercourse."

Dr. A. R. Stevens: "Normal sexual desire. Insufficient occupation—vocation and avocation. Alcoholism."

Dr. H. C. Taylor: "1. Alcohol—the first offense. 2. Late marriage."

Dr. J. W. Williams: "In males, uncontrolled sexual desire. In females, especially unmarried women after the thirties, curiosity."

Dr. A. C. Wood: "Sexual passion, uncontrolled or excited by a particularly attractive partner."

15. How frequent are cases of maladjustment in marriage resulting from the mental effects of premarital intercourse in men and women?

In group A, 4 individuals replied that cases of maladjustment in marriage due to the mental effects of premarital intercourse in men and women were frequent. In group B, only 3 replied affirmatively.

Dr. Helen W. Brown: "Rather frequent."

Dr. R. C. Bryan: "Practically always."

Dr. C. C. Wholey: "Maladjustment in marriage has, in my experience, resulted frequently if there has been premarital intercourse; this has been observed more frequently in those whose moral and ethical standards have been above the average."

In group A, 5 returned qualified answers, and in group B, 4.

Dr. J. A. Gardner: "Among men, I occasionally find impotence because of self-accusation; they feel that they should be as pure as their wives—mental impotency."

Dr. R. W. Hall: "Infrequent in men; more frequent in women, especially in the neuroses. But considering the amount of premarital intercourse indulged in, the percentage of later maladjustment must be low."

Dr. R. C. Hamill: "Not frequent as an isolated cause, but where such intercourse has always been with prostitutes, where it is considered as an indecent act of licentiousness, then it can count quite strongly."

The physicians who answer this question in the negative are numerous—21 in group A and 13 in group B. Types of answers are as follows:

Dr. T. H. Ames: "Relatively infrequent. Men do not object to their wives knowing that they had intercourse before marriage. Wives usually like their husbands to know how to conduct the sexual

act. Women—i. e., some women—are afraid their future husbands will discover that they are not virgins. This fear is apt to produce maladjustment after marriage. An answer to this question is dependent on the mental reaction in the individual who had intercourse before marriage.''

Dr. J. M. Baldy: ''Rarely. If the woman escapes results the first time, she usually goes on complacently, even if moderately. Time cures most things—and this is not excluded.''

Dr. A. A. Brill: ''I have never seen any maladjustment. On the contrary, the average man usually has had premarital intercourse and as a rule makes a better husband than those who have remained chaste. I can say the same of women.''

Dr. H. W. Frink: ''Premarital intercourse, on the part of men, rarely has any serious mental effects, according to my experience. Indeed, premarital *continence* seems to have much more frequent and serious ill results. I feel quite confident of the correctness of this conclusion, however distasteful from the moral or idealistic viewpoint it may be. Men who have been strictly continent before marriage certainly do not, as a class, make good husbands. The exceptions to this rule are most common in the case of very early marriages.

''In the case of premarital intercourse on the part of females, serious mental effects are rather common, though by no means invariable or inevitable. Most frequently they grow out of a sense of guilt and the defensive reactions against the same.''

Dr. J. Ramsay Hunt: ''In my opinion, not frequent.''

Dr. S. E. Jelliffe: ''Not very frequent.''

Dr. Ernest Jones: ''Never met one.''

Dr. J. M. Van Wart: ''This is answered largely by the educational status of the community. In this community, which is dominated largely by Latin influence, maladjustments due to this cause are not frequent. There is a marked tolerance toward premarital relationships between men.''

In group A, 5 physicians stated frankly that they did not know what to answer. In group B, 11 returned similar answers.

16. How frequent are cases of mental disturbance resulting from sexual abstinence?

Again on account of the importance of the question and the enormous variability in the replies, it seems best to quote all replies from both groups A and B.

Replies from Group A

Dr. E. Stanley Abbot: "I do not recall any."

Dr. T. H. Ames: "Here everything depends on the reaction to abstinence. If it was entirely voluntary and willing, no mental disturbance ever resulted. If the abstinence was forced because of ideals or environment and was not entirely '*freiwillig*,' mental disturbance and neuroses are frequent."

Dr. A. M. Barrett: "Not frequent."

Dr. A. A. Brill: "It is difficult to say what causes the disturbance. There are many neurotic disturbances as a result of abstinence, but mental disturbances are usually encountered in those who show a special constitution. The average normal person usually finds a way out of it long before he becomes disturbed."

Dr. Helen W. Brown: "Probably a contributing cause of some psychoses and almost surely the cause of many conflicts and complexes."

Dr. Sanger Brown, II: "Causes of mental disturbance are so complex that to blame one single factor would be misleading. Many adjust to this with fair success; many cannot or do not, and neuroses develop."

Dr. C. D. Camp: "Rarely the sole factor, but not infrequently a contributing cause, especially in women."

Dr. I. H. Coriat: "Have never observed it, although sexual abstinence with an over-moral repression may lead to severe neuroses in insufficiently and improperly sublimated individuals."

Dr. H. W. Frink: "Rarely is sexual abstinence *alone* a cause of mental disturbance. In many of the cases where it *seems* to have been a cause, a closer examination reveals the fact that there have been at work *pathological* repressions and resistances producing the abstinence, and that the mental disturbance is a result of the combined operation of these two factors. A person free from pathological sex resistance and sex repressions, and possessed of a reasonably sound constitution, ordinarily will not practice abstinence to the point where mental disturbance might supervene. Ere that point is reached, he will get *some sort* of sex outlet—masturbation, for example, if nothing better is available."

Dr. H. I. Gosline: "Never heard of a case."

Dr. W. W. Graves: "Seldom, if ever, in those we commonly recognize as normal."

Dr. T. H. Haines: "Believe them rare if existent."

Dr. R. W. Hall: "Infrequent *per se*. However, when substitutions for abstinence, as masturbation or perversions, are indulged in, the frequency is of course increased."

Dr. R. C. Hamill: "Frequent in those conditions in which such abstinence is gained."

Dr. Arthur Hamilton: "Sexual factors certainly are often intimately mixed with mental disturbances, but I think that sexual abstinence is only one of several factors. I do not believe that sexual abstinence alone is sufficient to produce mental disturbance, other matters being normal."

Dr. G. V. Hamilton: "I have never been able to arrive at an intelligent guess on this point. So many other possible factors may be adduced as a cause of mental disturbance in a given case that one is apt to list this with one of the unsolved problems of psychopathology."

Dr. J. Ramsay Hunt: "Very seldom. Not frequent except there be some mental repression or masturbation be excessive or of the mental type; then psychasthenia or neurasthenia may result (not insanity)."

Dr. S. E. Jelliffe: "Mild neurotic disturbances universal; severe disturbances extremely rare."

Dr. Ernest Jones: "Very."

Dr. John T. MacCurdy: "As a sole factor, it is unknown."

Dr. H. W. Mitchell: "Know of none."

Dr. Abraham Myerson: "Frequent in my experience; that is to say, neuroses have this basis, though psychoses do not."

Dr. Samuel T. Orton: "I doubt their occurrence."

Dr. Charles Ricksher: "I have never seen a case."

Dr. A. H. Ruggles: "Very infrequent."

Dr. S. I. Schwab: "None at all."

Dr. H. D. Singer: "This in my experience has not been a factor. The abstinent individual with a mental disorder has a general lack of frank social contact, and the sex life is only one illustration of the make-up. Mental disturbances from failure to satisfy the desire for offspring are more important than sexual intercourse."

Dr. H. C. Solomon: "I know of no authenticated instance where this has been the case."

Dr. A. W. Stearns: "Never."

Dr. Edward W. Taylor: "Occasional. But never under conditions of proper and adequate sublimation."

Dr. J. S. Vanteslaar: "The two conditions are sometimes met in the same person, but 'resulting from' does not describe their relationship!"

Dr. R. M. Van Wart: "Very infrequent. Usually in those cases where it has occurred it is due to the sex instinct being strongly developed."

Dr. W. A. White: "I doubt if abstinence in itself is a cause of mental disturbance; it is not infrequently a sign of biological inferiority."

Dr. C. C. Wholey: "Certain cases, particularly of dementia-praecox make-up, have impressed me as having succumbed to the D. P. trend because of sexual abstinence—or because of the failure to find an adequate outlet for the impulses arising from sex desire."

Dr. T. A. Williams: "Should we not rather say preoccupation?"

Dr. G. A. Young: "Have seen no cases of mental disturbance resulting from sexual abstinence except when associated with abnormal sex inhibitions or resistance."

Replies from Group B

Dr. F. L. Adair: "In my experience it is infrequent."

Dr. J. M. Baldy: "Not often unless there has been illicit indulgence, a desire for continuation of this exists strongly, and the indulgence is extremely difficult to obtain or even impossible."

Dr. L. H. Bernd: "None."

Dr. Horace Binney: "No case recalled."

Dr. R. C. Bryan: "Negligible."

Dr. H. T. Byford: "Seldom."

Dr. Hugh Cabot: "I believe mental disturbance of this origin much more common than generally believed. Have seen many cases in the male causing grave interference with work. In the female I believe it is the common cause of so-called nervous breakdown."

Dr. J. B. Clark: "Seen every day in the arrested and deflected mental processes of unmarried or unproductive women of advancing years. Abstinence in the normal male is less common—so much less that it makes the question difficult to answer."

Dr. A. H. Crosbie: "Very rare."

Dr. J. H. Cunningham: "The most frequent cause, as regards the sex relations between husband and wife."

Dr. Hugo Ehrensfest: "Not so rare, especially in young widows."

Dr. Ella B. Everitt: "Rare, because sexual abstinence in marriage is rare—and because in single life it is usually accompanied by sufficient knowledge of general and sex hygiene to make the continent life healthful."

Dr. F. E. Gardner: "Very few, if physical and mental activities have proper aims."

Dr. J. A. Gardner: "I don't know, but they are not unusual."

Dr. H. S. Kretschmer: "Look at any old maid, and count them. This can only be answered by a wild guess."

Dr. J. C. Litzenberg: "Not frequent—occasional only in my experience."

Dr. W. E. Lower: "I believe not infrequently."

Dr. W. P. Manton: "Depression and irritability—(mental) not insanity—frequent."

Dr. W. C. Quinby: "Do not occur."

Dr. Jeanette H. Sherman: "Not frequent."

Dr. E. H. Siter: "More often in the female than in the male."

Dr. G. G. Smith: "I have seen none."

Dr. A. R. Stevens: "Don't see them."

Dr. J. H. Stokes: "Responsible for an indefinite percentage of storm and stress."

Dr. G. K. Swinburne: "Do not believe to be very frequent."

Dr. H. C. Taylor: "Rare."

Dr. G. S. Whiteside: "Quite frequent. *Vide* girls of the well-to-do class with nervous prostration and crank ideas."

Dr. J. W. Williams: "Almost unknown in normal individuals."

17. Do you consider that absolute continence is always to be insisted upon or may it be taught that under certain conditions intercourse in the unmarried is harmless or beneficial?

The replies to the above question are again so varied and offer so many different points of view that we present them in a body.

Replies from Group A

Dr. E. Stanley Abbot: "I know of no harm from absolute continence. Intercourse in the unmarried cannot be justified on any grounds of health or morals."

Dr. T. H. Ames: "a. No. For some absolute continence would be easy, for others impossible. It is an individual problem to be decided by the individual, with or without advice."

"b. Under certain conditions in the unmarried, male or female, intercourse is harmless or beneficial; under other conditions, it is harmful and injurious (irrespective of venereal disease)."

Dr. A. M. Barrett: "Continence is desirable. There may be personal situations where intercourse in the unmarried may be beneficial."

Dr. A. A. Brill: "Years ago I encouraged intercourse in some neurotics who were constantly worrying about sex. I soon found that it had not benefited them. The same factors which produced the original conflicts continued to disturb them. Now I remove their conflicts by analysis, and then they need no advice. I know of a number of cases who have successfully abstained from 2-3 years following analysis."

Dr. Helen W. Brown. "No. It is probably well to teach young people that continence before marriage is in general very desirable, as contrasted with the result of incontinence."

Dr. Sanger Brown, II: "Adults will probably decide this for themselves. If positively, they should know of possible injury to others through venereal disease, and the possible influence on others."

Dr. C. D. Camp: "It is best to teach conformity to custom."

Dr. I. H. Coriat: "Absolute continence should always be insisted upon."

Dr. H. W. Frink: "Absolute abstinence from all and every form of sex gratification, maintained for a long period, would be a thoroughly unnatural condition, which, *if* it could be achieved, would certainly and invariably be productive of serious harmful results. Absolute continence *from intercourse* should never be invariably and unqualifiedly insisted upon. A large proportion of women, particularly young women, can achieve such continence without great effort, and without ill effects. But in the case of *some* young women, in that of many mature women (especially those who have been 'roused'), and in that of a very large proportion of men both young and mature, the effort to achieve such continence, or the achieving of it, would be much more likely to work harm than temperate and intelligently undertaken indulgence. In short, indulgence, under certain circumstances, may not only be harmless, but may likewise be beneficial and very necessary.

"I have no doubt of the truth of these statements. I have little uncertainty as to the desirability of having the truth about these matters generally known by the public. On the other hand, a campaign of truth-telling would certainly meet with great and violent opposition, and should, if undertaken at all, be carried on in the most skillful and careful manner possible."

Dr. H. I. Gosline: "Physically it may be harmless and beneficial, though in some cases dangerous even in the married state. Moral and ethical considerations and, I believe, economic considerations contradict it."

Dr. W. W. Graves: "I know of no condition where one is justified in advising the unmarried that intercourse is harmless or beneficial."

Dr. T. H. Haines: "Absolute continence."

Dr. R. W. Hall: "The first should not be insisted on any more than the latter should be recommended. The army venereal *Vade Mecum* said intercourse is not essential (as I recall it) and a little amplification of this is wiser than strait-laced insistences which a goodly proportion of men would ignore if opportunity occurred."

Dr. R. C. Hamill: "The latter may be taught."

Dr. Arthur Hamilton: "This involves more than one question. Our particular world says this is morally wrong. Even if it were not so recognized, the danger of acquiring sexual diseases is so great that continence ought to be insisted upon."

Dr. G. V. Hamilton: "I have always insisted upon absolute continence in the unmarried. This question must always be answered with reference to much broader issues than are contained in the welfare of a given individual."

Dr. William Healy: "Not convinced either way."

Dr. J. Ramsay Hunt: "Absolute continence should be preached as a doctrine to the unmarried, and let the individual adjust himself to this stern law according to his *lights!*"

Dr. S. E. Jelliffe: "I believe the former course consistent with good health; with instruction as to certain symptoms due to abstinence—great betterment. There may be instances of latter advice being beneficial, but I have never seen them particularly. Bodily disorder may be minimized, but mental and sublimated values are apt to suffer."

Dr. Ernest Jones: "It is always harmless, obviously, except socially. Continence, if continued, is rarely harmless."

Dr. J. T. MacCurdy: "I believe that this question can only be answered in individual cases on the basis of the personality and environment of the subject. I may state that my practice is to explain fully to my patients all the remote, as well as immediate, consequences that I know of and let them make their own decision. As a matter of fact, they almost always decide in favor of continence, and seem, when they have gained proper control of themselves in other ways, to be perfectly comfortable in spite of this inhibition."

Dr. H. W. Mitchell: "I believe it should be taught for the benefit of society, so long as we do not uphold polygamy and defend existing moral teaching."

Dr. Abraham Myerson: "This question would require a book for answer. From the physical standpoint, continence is in my opinion harmful. From the standpoint of society as it is to-day organized, it is necessary. The human being is placed on the horns of a dilemma which I cannot offhand solve."

Dr. Samuel T. Orton: "I consider absolute continence to be the only open course—not only of morals, but also of hygiene."

Dr. Charles Ricksher: "Whether one is continent or not depends upon one's training and habits."

Dr. A. H. Ruggles: "I believe absolute continence in the unmarried should be insisted upon."

Dr. S. I. Schwab: "Absolute continence is the social aim to be tried for. Its unphysiological basis must be explained."

Dr. H. D. Singer: "I certainly should not teach the permissibility of intercourse, but would rather instruct in means for satisfying the innate desire for reproduction by substitute interests and also means for expending the energy of sexual congress and the avoidance of stimulation."

Dr. H. C. Solomon: "I should be inclined to feel that there are certain exceptions to be considered."

Dr. A. W. Stearns: "Consider it an ideal towards which to strive, but which majority never reach."

Dr. Edward W. Taylor: "From the social standpoint, continence is desirable."

Dr. J. S. Vanteslaar: "A proper understanding of sex hygiene would not lead any one to expect a dogmatic standpoint on this question. Different persons solve this problem for themselves—with equal success or failure as the case may be. (Wish space permitted more extended answer.)"

Dr. R. M. Van Wart: "This can be best answered by giving my experience. The only condition where absolute continence has given rise to this difficulty has been in psychopathic individuals or in individuals otherwise normal who have been left without normal outlet at the death of husband or wife. These cases have not been numerous."

Dr. W. A. White: "I believe that the teacher must necessarily stand for the social conventions."

Dr. C. C. Wholey: "There might arise individual instances where absolute continence should not, for a time, be insisted upon, but such teaching should not be general."

Dr. T. A. Williams: "Problem unsolved."

Dr. G. A. Young: "I think that absolute continence in the young should be insisted on; that in certain cases it is beneficial as representing the best adjustment possible in individuals of mature years."

Replies from Group B

Dr. F. L. Adair: "I think absolute continence should be insisted upon as the ideal in our present social system. I would say that intercourse in the unmarried is not pathologic, but may cause social harm."

Dr. J. M. Baldy: "I think it is harmless and beneficial—but our standards are against it and who could possibly conscientiously teach such a thing, no matter what he thought?"

Dr. L. H. Bernd: "There are no harmful effects from absolute continence, as shown by the health and general tone of the majority of the soldiers of the A. E. F. Despite the so-called immorality of our men, the majority who did not get drunk were continent."

Dr. Horace Binney: "I consider the latter teaching very dangerous."

Dr. R. C. Bryan: "Continence."

Dr. H. T. Byford: "Absolute continence for both sexes."

Dr. Hugh Cabot: "Though I do not believe that absolute continence is always desirable for all people, I am so unable to draw the line that I think the only safe teaching is continence."

Dr. J. B. Clark: "Sexual relationship is the individual's affair —so long as no other person, or persons, or society is harmfully affected by it."

Dr. A. H. Crosbie: "Continence is consistent with perfect health. I should never advise intercourse in the unmarried."

Dr. J. H. Cunningham: "Advice seems dangerous, especially with the prevalence of venereal disease, and if the sex appetite is normal, such a matter takes care of itself and the less said about it the better."

Dr. Hugo Ehrensfest: "Moderate masturbation is the solution, in my belief."

Dr. Ella B. Everitt: "Absolute continence in the unmarried is essential to the safeguarding of all that is best in human nature and in the national life."

Dr. F. E. Gardner: "Absolute continence is *always* the goal; *never* teach that intercourse is beneficial; there will be enough slips, anyway, without undermining the power of resistance of the young by such a teaching, which I consider absolutely false."

Dr. J. A. Gardner: "I do not believe that continence should be insisted upon."

Dr. H. S. Kretschmer: "The first part. This will depend upon the individual; hence it is an absolutely individual problem. If you teach the second part, the amount of promiscuous intercourse will increase beyond our present powers of conception."

Dr. J. C. Litzenberg: "Yes" (continence always to be insisted upon). "No" (to the latter part of the question).

Dr. W. E. Lower: "I do not believe that absolute continence is always to be insisted upon."

Dr. W. P. Manton: "No. Yet in matter of advice—there's the rub—without appearing to countenance prostitution."

Dr. W. C. Quinby: "Should *not* so teach."

Dr. Jeanette H. Sherman: "Never wise to teach anything but the highest standards."

Dr. E. H. Siter: "Continence should be advised. The individual sex feeling will be the controlling factor, coupled with opportunity."

Dr. G. G. Smith: "I believe that Robie is right when he says that occasional masturbation to relieve the sexual pressure is safer than intercourse. I never advise illicit intercourse."

Dr. A. R. Stevens: "We should urge continence in the unmarried—that coitus is morally and socially wrong, although physically harmless if venereal disease is not contracted."

Dr. G. K. Swinburne: "Theoretically I believe in absolute continence."

Dr. G. S. Whiteside: "Since prohibition and other laws suppressing almost everything, sex instinct is the only amusement left that can never be legislated out of existence."

Dr. J. W. Williams: "Yes, I consider that the physician should hesitate to give advice to the contrary, as he would then be more or less responsible for the consequences."

Dr. A. C. Wood: "Prefer to insist upon continence in the unmarried."

18. In addition to masturbation, are any other perversions frequent enough to justify popular education concerning them?[1]

In both groups A and B, the replies spoke unqualifiedly against popular education concerning sex perversions. In group A, 20 and in group B, 20 replied that instruction concerning perversions other than masturbation was unwise. In group A, 10 individuals and in group B, 2 would add instruction upon one or more of the following perversions here listed. The numbers in the brackets show the number of times the answer was met with:

1 A very large number of the physicians objected to the authors' use of the term "perversions" in connection with masturbation. Our use of the term is correct and carries with it no moral significance whatsoever. We use the term "perversions" in its etymological sense, meaning merely that the sex act was not a heterosexual adjustment.

Homosexuality [10]
Mutual masturbation [2]
Pederasty [2]
Coitus interruptus [1]
Cunnilingus [1]
Sadism [1]

19. What conditions do you consider most essential for proper sexual adjustment in marriage?

As in certain of the other questions, it seems wisest here to give a complete statement of all of the replies from at least one group. We have selected group A in view of the fact that the psychopathologists have had not only to meet such questions at the hands of their patients most often, but also to give time and thought to the analysis of such maladjustments.

Dr. E. Stanley Abbot: "Frankness and openness, without prudery; mutual consideration, each for the other's desire or lack of desire in the sex relations; freedom from venereal disease."

Dr. T. H. Ames: "1. Understanding of the physiological reaction of the opposite sex and own sex. 2. Understanding of the psychological reaction to sexual matters in general and specifically. 3. Patience until 'practice makes perfect'—i. e., both husband and wife attain synchronously the orgasm. 4. Willingness to satisfy the mate."

Dr. A. A. Brill: "Physical and mental health; full sexual knowledge on the part of the man and woman, especially in the former."

Dr. Helen W. Brown: "Normal health. Reasonable youthfulness of soul, common sense, and unselfishness. Some understanding of normal physiology. Some similarity in ideals."

Dr. Sanger Brown, II: "Perfect frankness, without reservations or misunderstanding. Many things can be adjusted if this exists."

Dr. C. D. Camp: "Harmonious ideas and ideals. In my opinion this could be more surely brought about by allowing the one to educate the other. Outside interference is usually the trouble maker, and this interference can take place either before or after marriage."

Dr. I. H. Coriat: "A complete understanding from the social and biological viewpoints of the sexual problems, particularly an insistence that sexuality is not unclean, but is a deep and primal

instinct. The husband and wife should also attempt to meet on a common emotional level.''

Dr. H. W. Frink: ''' 'Proper sexual adjustment in marriage' is something of pretty rare occurrence. I think it is likely to remain a comparative rarity as long as marriage is not prepared for by proper sexual education. Proper sexual adjustment in marriage is, in my experience, most commonly to be observed among people of little education and culture—i. e., those who have been spared the care bestowed upon children by parents of means, education, and more strict notions of propriety. Children from large families certainly make, as a rule, better husbands and wives than those from small families.

''For proper sexual adjustment to be at all general will require, in my opinion, general sexual education from early childhood up, including education, probably of both the male and female, in the *ars amandi*, a general knowledge of the use of contraceptions, and, very probably, eventually some quite extensive changes in sexual and marital ethics. I am inclined to think that trial marriage should be considered in this connection.''

Dr. H. I. Gosline: ''Knowledge of anatomy and physiology of the parts, of how to produce the proper agreeable concomitant effects, of how to prevent conception, and of the proper physical, mental, and economic conditions in which to produce. I feel that such knowledge will produce a better race and will not lead to race suicide.''

Dr. W. W. Graves: ''1. Age (the male should be older than the female, but never more than fifteen years older; ideal is from one to five years older). 2. Mutual respect. 3. Children. 4. Economic conditions. 5. Approximately the same social level.''

Dr. R. W. Hall: ''A tolerant understanding and appreciation of the individual and the mate's needs (cravings) and problems. I do not mean, of course, a yielding to perverted cravings. But in the therapy of the neuroses and psychoses, one big problem is to find out the lines of the patient's cravings for satisfaction and happiness and the way in which he handles these problems. The physiological form of this problem enters largely into every marriage. As a bachelor's commentary on the question, I would say that one important reason for husband, especially, and also wife's getting fed up with a marital sexual status and seeking new pastures is that the relationship is too often taken as a matter of course and becomes a deadly routine. I recall many smash-ups that could have been avoided if the husband had been made to dangle at arm's length from time to time.''

Dr. R. C. Hamill: ''Respect of individuals for each other. Not too great a value placed upon chastity by the woman; if the value is very high and it is not appreciated in the same manner by the

man, there is cause for misunderstanding, the woman having a feeling of lack of proper estimation by the man of her treasure.''

Dr. Arthur Hamilton: ''Physical health. Normal mental attitude toward sexual matters, which can be aided by satisfactory instruction. See No. 5. Marriage based on affection.''

Dr. G. V. Hamilton: ''General fitness of male and female to be mates to one another; careful instruction of both on eve of marriage as to copulative function; instruction as to how pregnancy may be harmlessly avoided, without interfering with pleasure of coitus; avoidance of all possible grounds for friction, such as the distribution of the family income, the relation of mother-in-law to the family, etc. Avoidance of initial sexual excesses is to be taught young married couples.''

Dr. J. Ramsay Hunt: ''A healthy body with normal glandular relationship. A normal mind with consciousness of sexual desires and these directed toward the normal sexual object, without aversion or conflict of any kind.''

Dr. S. E. Jelliffe: ''Frankness in mutual service; consideration of the partner; knowledge concerning the process and its psychological importance rather than the mere physical details.''

Dr. Ernest Jones: ''Objectivity—i. e., freedom of thought and a natural attitude toward sex, as toward other human attributes.''

Dr. H. W. Mitchell: ''Comfortable living conditions with fair prospects, good health, similar tastes, and 'common sense' in meeting matrimonial difficulties.''

Dr. Abraham Myerson: ''Proper adjustment would depend upon (1) capacity of each person to gratify the mate; (2) gentleness, consideration, and what might be called courtship on the part of the male, with similar though less marked adjustment on the part of the female. The partner should be of nearly equal age, and it should be emphasized to both of the parties that maintaining neatness and beauty as much as is possible is important. In my opinion, separate rooms or separate beds are valuable to the majority of people.''

Dr. Samuel T. Orton: ''A reasonably broad understanding of the fundamental sex relations of both plants and animals, with the explanation that human sex relations are just as fundamental and in essence no more complex.''

Dr. Charles Ricksher: ''Proper development of the sexual organs and a common-sense attitude toward sexual matters.''

Dr. A. H. Ruggles: ''The husband and wife should both be normal individuals.''

Dr. S. I. Schwab: "1. Attraction. 2. Mutual affection. 3. Physical liking. 4. Sexual inhibition mutually appreciated. 5. A certain aspect of idealism to the sexual act."

Dr. H. D. Singer: "A most important condition I believe to be mutual regard and lack of too much egotism on the part of either person. I believe that if there is sufficient regard and not too much egocentricity, this matter will be satisfactorily adjusted, irrespective of a great amount of knowledge."

Dr. A. W. Stearns: "Ardent love and a certain amount of ignorance."

Dr. Edward W. Taylor: "1. Knowledge. 2. Insistence that sexual relations are not the sole end of marriage."

Dr. J. S. Vanteslaar: "1. Understanding of physiology of coitus on part of both. 2. Relief from all inhibitory, taboo feelings concerning sex. 3. Appreciation of rôle of sex beyond its biological implications. 4. Recognition of sexual relation as merely the physiologic side of a complete circle of relationships which it serves as much as [they?] serve it in turn. 5. Absence of anatomic or physiologic hindrances."

Dr. W. A. White: "An intelligent, constructive attitude toward the love relationship which recognizes that marriage will enable both parties to go together into a situation offering enlarged possibilties of personal expression which will make them happier and therefore socially more successful and useful."

Dr. C. C. Wholey: "Theoretically, similarity of age, health, compatible religious views, similar educational standards, etc. Actually one meets with apparent adjustments under most contradictory circumstances."

Dr. T. A. Williams: "Physiologic, æsthetic, psychic."

II. With Respect to Sex Instruction Before Maturity

20. Do you consider that changes in the development of the child justify the division of pre-adolescent years into definite periods demanding special sex control or instruction? . . . If so, what are the periods and what special methods should be adopted in each?

The answers to this question, while full, are rather indefinite and with difficulty lend themselves to analysis. We shall consider first the answers to the question as to whether pre-adolescent years should be divided into definite periods in

which special sex instruction should be given. In group A, 11 returned unqualified affirmative answers; in group B, 6. Types of replies are as follows:

Dr. T. H. Ames: "Yes. In my experience children show sexual interest or acts at ages 1 to 2 or 3, 8 to 10, and from the age of puberty onward (12 or 14 up). Disciplinary methods are most efficacious at the age of 1-3; but educational are better above the age of 6."

Dr. G. V. Hamilton: "Yes. (a) Before the fifth year the child should be told that fathers plant baby seeds in the mothers' bodies, causing babies to grow under the mothers' hearts, etc. No anatomical details given. (b) At seven, eight, or nine, depending on development of child, he (or she) should be told that the planting is accomplished by the agency of particular organs, and be given parallel examples by having flowers dissected and explained in terms of reproductive functions. (c) After this, as soon as child betrays curiosity, the facts of desire for copulation and the obligation to regulate such desire with reference to ideals of conduct should be given. (Before puberty.)"

Dr. S. E. Jelliffe: "I do. Periods are definite, but vary chronologically with child. Instruction chiefly of the mother and her sympathy with the child's curiosity and common-sense ways of dealing with it. The periods in general may be termed (1) organ-erotic period, 1-7; (2) narcissistic period or auto-erotic period, 7-14; (3) socialized period, 14 on. Years only general."

Dr. J. T. MacCurdy: "I think that we may adopt, roughly, the Freudian classification of infantile, latent, and adolescent periods. The infantile period should end about the age of 4, 5, or 6—in other words, the pre-school period. Education of the children at this time depends on parents and nurses, and should aim chiefly at the inculcation of a normal attitude toward bodily processes. By normal I mean a recognition of the naturalness of them without any feeling of shame, but with a recognition of publicity being bad manners. During this period many children have considerable sex curiosity which parents should be taught to quiet with perfectly common-sense and accurate answers appropriate to the intelligence of the child. During the latent period, which runs on to puberty, children should learn the fundamental facts of sex so thoroughly that it is a commonplace to them. In the adolescent, education should be designed essentially to prepare the youth for the responsibilities of marriage. In all stages parents ought to be the best instructors, but are rarely intelligent or dispassionate enough to perform their duty properly; consequently paid teachers have to do it. As a matter of fact, I think it probable that parents, by example, contribute more to the actual education of their children along these lines than they fancy."

Dr. H. C. Solomon: "The period in which sex interest develops differs in individual children. Occurring, as it frequently does, around the age of 4 or 6, it demands attention and instruction of a type that is understandable for a child of this age. It would seem that this is the time that the confidence of the child should be gained, and where this is done the future education has a better basis. I believe that a continuation of this instruction is needed for the individual child, and should be carried on to a period just preceding puberty, without any special relation to set rules or laws. Just preceding puberty, a broader outline is demanded for all children, whether they have apparently shown special interest or not. At this time, according to the usual school system, the average child has begun to learn something about physiology. This could be a basis for instruction and then more intimate instruction given in addition."

In group A, there were 6 individuals and in group B, 4 individuals who would accept some kind of a rough division of ages for purposes of instruction. Types of replies are as follows:

Dr. R. M. Van Wart: "This seems to be again an individual problem. In certain individuals where sex precocity exists, education should be undertaken at an early period and where curiosity concerning this matter is not especially developed."

Dr. W. A. White: "Only roughly. Such as the auto-erotic, homosexual, and early heterosexual stages. The development should be known sufficiently to appreciate the dangers of the different periods so as to guard against the child being sidetracked at any one of them; for example, guarding against too prolonged and too serious 'crushes' between girls. The methods in general should be those of indirection rather than attempting the repression of these tendencies; the development of attractions should assist the child in the readjustment of its libido to progressively more desirable objects."

The great majority of the answers did not favor any division of the pre-adolescent years for special types of instruction: 16 in group A and 16 in group B, while favoring instruction at some time, did not believe in special instruction at set ages. Types of replies are as follows:

Dr. Hugh Cabot: "I do not think that definite periods can be assigned. The best results I have seen have been reached by following the child's development and supplying information and explanation as it is demanded. Undoubtedly the best results are obtained by efficient personal teaching."

Dr. Hugo Ehrensfest: "I do not think that hard-and-fast rules concerning division can be made. The necessity and extent of information to be given probably in the average case can be determined by the questions concerning sex matters the child asks, care to be taken that questions asked in mere curiosity are not mistaken for those asked in the desire to have certain information."

Dr. F. E. Gardner: "No. The general principle of instruction seems to be more to *follow* what the child finds from observation of himself and explain those facts to him than to 'whet' his appetite by *going ahead* of nature. Of course, such a method presupposes absolute frankness and confidence between the child or adolescent and his adviser."

Dr. H. I. Gosline: "No. Quit socializing. Individualize. Quit fossilizing. Provide the opportunity, remove the slur and the stigma from those who ask questions, and the questions will be asked by the individual at the proper time for him or her."

In regard to the different periods or ages at which special instruction should be given, our quotations above under the unqualified affirmative types of answers show the only data we have bearing upon this subject; the other affirmative replies left the matter of age too indefinite for analysis.

The replies as a whole spoke unqualifiedly for the beginning of instruction at the first manifestation of curiosity, for the individualizing of the child, and for giving him information just as rapidly as he can completely assimilate it, giving possibly special instruction concerning venereal disease after puberty, and special instruction concerning coitus at the marital age.

21. Should instruction at puberty aim to cover the field of sexual physiology or be restricted to explanation of the processes coming within the child's experience at this time?

In group A, 16 and in group B, 7 replied that instruction at puberty should cover the whole field of sexual physiology.

In group A, 19 and in group B, 18 would limit the field of sex instruction to explanation of the processes coming within the child's experience at this time. Most of the answers of this type, however, were perfectly willing to take the child as far as his curiosity would go, even if it covered the whole field of sexual physiology. It should be understood that the physicians, in returning this reply, were assuming that instruction had begun at an early age and had been given by

sympathetic parents or physicians. The fact was not brought out, although it seemed to be implied, that where children are brought up in families where questions concerning sex are frowned upon, they will not ask of their parents answers even to questions which their own bodies raise or those which will be raised by their comrades and associates. The replies as a whole failed to throw very much light upon the handling of such cases. They are probably more numerous than the other type.

Replies Indicating that Instruction Should Cover the Field of Sex Physiology

Dr. T. H. Ames: "Should cover both the child's experience and the physiology in general."

Dr. A. H. Crosbie: "I see no harm in covering the field."

Dr. Hugo Ehrensfest: "Should *not* be limited to processes coming within personal experience."

Dr. W. W. Graves: "It is at this period that full instruction should be given in sexual physiology."

Dr. G. V. Hamilton: "A simple, but literal and scientifically accurate outline of sexual physiology ought to be given at puberty, with warning that such and such yearnings will come and must be handled with reference to the rights of society and the exclusive rights of the wife that will some day share the experiences that will satisfy such yearnings, etc."

Replies Indicating that Instruction Should be Limited to the Processes Coming Within the Child's Experience at Puberty

Dr. J. M. Baldy: "The latter if at all."

Dr. J. A. Gardner: "Restricted to explanation of the processes coming within the child's experience at this time."

Dr. S. E. Jelliffe: "Chiefly individualized, personal, and private with reference to child's own questionings and experience. General instruction chiefly through general processes."

Dr. J. C. Litzenberg: "Each child should be carried along according to mental development in graduated stages."

Dr. W. A. White: "As far as possible, instruction should be limited to matters coming within the experience of the child or matters about which the child has curiosity. In the latter case instruction should be limited to satisfying the curiosity rather than attempting to make the information complete."

22. Is there danger of arousing too great interest in sex matters by detailed instruction at this time?

In group A, 24 individuals and in group B, 26 were decidedly of the opinion that there is very great danger of arousing too great interest in sex matters at this age.

In group A, 12 individuals and in group B, 5 stated that there is no danger, adding the proviso in many cases that the instruction must be proper and the instructor well qualified for his task.

23. Is this offset by the danger of establishing false beliefs, in the absence of proper instruction, which may lead to difficulties of adjustment later?

In group A, 21 physicians and in group B, 12 replied that the possibility of false beliefs being established in the absence of proper instruction was greater than the danger of arousing too great interest in sex matters by instruction at puberty. In other words, they returned a positive answer to the above question.

In group A, 10 individuals and in group B, 12 implied or stated directly that they felt that the danger of arousing undue interest by instruction was not offset by the possibility of false beliefs being established in the absence of proper instruction.

24. Should instruction concerning the existence of prostitution be given at this time?

In group A, 19 individuals and in group B, 10 replied in the affirmative.

In group A, 8 and in group B, 9 answered affirmatively with certain qualifications. In all 17 of these qualified replies, the qualification consisted in one or more of the following things: (a) that the information should come a little later; (b) that the information should come only if the child asks for it; (c) that it should be given to boys and not to girls.

25. What instruction do you advise concerning masturbation? Should it be the same for children and adults? For both sexes?

In view of the tremendous importance attaching to this question, it seems best to quote the replies fully. On account of space limitations, only the replies received from group A will be presented.

Dr. E. Stanley Abbot: "(a) The truth without exaggeration or prejudice—no one was ever made insane by it; it is better than extra-marital intercourse; continence is better still. In excess, it is more harmful to the growing person than after full adulthood. (b) No, for you can give reasons to the adult that the child cannot understand. (c) My impression is that the effects are different in girls; to that extent the instruction should be different."

Dr. T. H. Ames: "(a) That it is normal, to be expected, a childish ('kiddish') trick to be experienced, thoroughly enjoyed, and discarded. (b) Yes, children and adults are alike in this matter; adults *are* children here. (c) Yes, males and females masturbate, usually hypocrites."

Dr. A. A. Brill: "Masturbation does not harm, but it is a manifestation of auto-erotism if frequently indulged; hence truth should be told to all, but in different language to children."

Dr. Helen W. Brown: "Each case should be dealt with individually, according to the psychology of the individual, etc. No one should be terrorized. In general children should be kept out or trained out of such habits. For adults of both sexes it is impossible to advise without a history and make-up of the case."

Dr. Sanger Brown, II: "Certainly different for children than adults. Proper advice can scarcely be given without study of each case."

Dr. C. D. Camp: "That it is harmless, but not nice or decent. Respect for oneself should be the strongest motive against it. Same for both sexes and for children and adults."

Dr. I. H. Coriat: "That masturbation does not lead to insanity, that it is merely an easy method of obtaining pleasure from one's own body, that because of the ease of gratification it may become a habit leading to unhealthy sexual fantasies, with a consequent distaste for the exercise of the normal functions of sexuality. Instruction in avoidance of masturbation should be the same for children and adults and for both sexes."

Dr. H. W. Frink: "That masturbation in youth in our civilization is well-nigh physiological, and that if practiced in moderation,

it is ordinarily harmless. Temperance rather than abstinence should be the aim of the adolescent, in most cases.

"As regards masturbation in infants and children, parents should know that the practice is very common, and that ignorant efforts to stop or control it are usually infinitely more serious than the masturbation itself. In general they may be advised that it is *usually* harmless, but that in every case it is better to get some *expert* medical opinion, particularly if the practice occurs between the sixth year and puberty. Very gentle efforts to make the young child stop or control it are ordinarily all right, but threats and punishment should *never* be employed. Rewards are all right and may be recommended.

"Instruction for adolescents and adults should be different. Both should know that if the practice may be regarded as pretty nearly normal for the adolescent, it is not so for the adult. Masturbation in the adult male means an arrest or an inhibition of development, and the adult should be advised to consult an expert, as no general line of instruction can be given. It may be stated that ordinarily it is not very serious, particularly in the case of unmarried females or others who practice it *faute de mieux.*"

Dr. H. I. Gosline: "Individualize it. Suit the case at hand."

Dr. W. W. Graves: "Instruction should be the same for children and adults and for both sexes. The individual should be taught that it is an unnatural way of sex gratification; that the habit is easily formed; that, if given up, no harmful consequences are to be feared; that it should not be indulged in, not because the act itself is harmful, but because it is unnatural, and that it is not manly or womanly to indulge in a filthy habit."

Dr. T. H. Haines: "Recognition necessary in sane sex instruction, to boys and girls. With boys counteract fakers who advertise the dangers of wet dreams. Emphasize the way to avoid these dangers by clean living and athletics."

Dr. R. W. Hall: "A frank presentation of the facts—that it is a widespread habit especially just before puberty, probably more common in boys than in girls; that it is not followed by the popular propaganda of quack literature—'drying up of the brain,' etc.—but that its continuance is evidence of weak will and lack of self-control; that the harm of the habit lies mainly in the individual's attitude toward it; that it is maintained in response to sexual cravings, but it is an unhealthy way to meet these cravings. Some allied simple example of the value of repression may be added here, as for example the folly and bad effects of temper tantrums. It may be dealt with in a constructive way by emphasizing the relationship between the sexual desire and race propagation, flavored with the usual sauce of diverting activities, sports, etc. Oftentimes a frank ventilation of the problem is all the boy who is having difficulties needs, and even an inexperienced doctor is probably better than none in this respect. As an extra added attraction emphasis

is laid on the fact that indulgence in masturbation is not conducive to the virility which the future prospective husband or wife desires. The whole problem should be presented with emphasis on the positive rather than the negative aspects.

"I should say the information should be the same for children as for adults, for when the masturbation problem comes into a child's life, he is an adult in that respect.

"I see no reason for differentiating between the sexes, for in its broad aspects the problem is the same, and the detailed sexual differences in masturbation I see no reason for going into. One does come across patients (mostly women) occasionally who as girls masturbated without knowing just what they were doing, but emphasis on its relation to sexual desire and satisfaction should obviate this aspect."

Dr. R. C. Hamill: "That it is a natural phenomenon and has a function of considerable importance in the education of the child. The same at all ages."

Dr. Arthur Hamilton: "No. Yes."

Dr. G. V. Hamilton: "Detailed, unexaggerated instruction, without reference to age or sex. It should be described as always dangerous, and never to be resorted to; but care must be taken to reassure patients who cannot wholly overcome an established habit."

Dr. William Healy: "I advise nothing but meeting the special problem of the given individual."

Dr. J. Ramsay Hunt: "It should be the same and should be eminently sane and sensible, recognizing that it is a very widespread and natural habit; and not associate with it exaggerated fear, harm, or insanity, as this often has an important bearing in the later general development."

Dr. S. E. Jelliffe: "The instruction regarding the physiology and psychology of function. It cannot be the same for children and adults, quite. Sexes more or less alike."

Dr. Ernest Jones: "No instruction, except in rare cases (where conflict is injuring)."

Dr. J. T. MacCurdy: "I would advise instruction which emphasizes two points: one, the physical harmlessness of the practice, and, two, the danger of it as a selfish, futile pastime. There is no reason for instruction being different for children and adults of both sexes, unless special complications have arisen which differ naturally with age and sex."

Dr. H. W. Mitchell: "Believe that same advice against the habit should always be given. Children and adults alike might well know that control of an animal function is advisable."

Dr. Abraham Myerson: "Instruction concerning its harm, laying some emphasis on its taboo nature. Instruction should be different for children and adults, should be the same for both sexes."

Dr. Samuel T. Orton: "I object seriously to the hell-fire-and-brimstone threats usually held out as the inescapable results of masturbation in children. I think they should be warned against it by sensible explanation of the physiological dangers of excessive sexual stimulation and over-drainage, but feel that the usual approach loses force because of the extreme position taken. I feel that masturbation is frequently symptomatic of mental or nervous disease and rarely if ever a causal factor except in the introspective or self accusatory."

Dr. Charles Ricksher: "That it is a perversion—is not necessarily harmful, except mentally in that it produces shame—and that it is rather a stupid way to avoid real relations. Adults and children should receive the same instruction."

Dr. A. H. Ruggles: "Advice as to its abnormality, and teaching the desirability of making sexual life in every way approximate the normal; it should be the same for children and adults and for both sexes."

Dr. S. I. Schwab: "I am very much in doubt."

Dr. H. D. Singer: "The problem here is identical with that of other appetites. It is part of the general proposition of self-control and sublimation of sensuality."

Dr. H. C. Solomon: "I should advise talking the matter of masturbation over fairly frankly and not placing it on a plane of great moral turpitude or damage to the future of the individual. In other words, one must, I think, put the same effort on combating the quack-medicine propaganda and scare literature. A child should be taught the reasons against, and should in no way have it held up as a terrible experience which will lead to ruination. One sees so many people, adults and adolescents, who have had their lives made miserable by morbid fears and worries as the result of improper knowledge in this regard. In my experience the bad results are about the same in both sexes, which would lead me to believe that instruction in this line is as necessary for one sex as the other."

Dr. A. W. Stearns: "Yes. Yes. Should be told of foolishness, but not subjected to exaggeration and romancing about evils."

Dr. Edward W. Taylor: "*Wholly inadvisable* as a habit—but not fundamentally injurious, except in excess. Boys worse offenders."

Dr. R. M. Van Wart: "The children should be warned against this habit. Instruction should be adapted to the age and sex."

Dr. W. A. White: "With regard to masturbation, it would probably be better to limit instruction in any detail regarding it to individuals where there is some intimation that it is being excessively indulged in. Such instruction should be free from the terrorism so frequently associated with ideas regarding this practice, and the child should be made to understand that the real danger is in continuing after its wrongfulness has been appreciated. Then again the real danger should be emphasized as making for selfishness and the prevention of the development of those qualities of mind which enable one to take one's place as a self-respecting, independent member of the herd, and so tending to impair his possibilities for future success, including adequate relationship with a wife and children."

Dr. C. C. Wholey: "Its harmful effects to development of strong men and women, etc. In children emphasizing chiefly its physical harm; in adults and children it often becomes necessary to discover the part that masturbation is playing in the psychic life, the whole problem being one of treating a psychoneurosis. In dealing with this subject generally, it should be taken up with both sexes separately, and the matter should be dealt with in addition to what has been said in the way of pointing out its effects in creating a nervous constitution, drawing the individual away from healthful physical and mental development—its perversion of family and social instincts and substitution of selfishness and unsocial habits. Dwell upon its prevention of the development of fearlessness and complete self-realization. Explain to both young and old the nature, the character of sex dreams and emissions, and neutralize in every way possible the growth of fear of loss of manhood and the other evil effects of patent-medicine propaganda and unfounded ideas that appeal to the minds of the public along these lines. Dwell on the ideas and means of obtaining healthful substitution and sublimation."

Dr. T. A. Williams: "Explanation. Yes. Yes."

26. Is the average parent sufficiently capable or free from inhibitions (even when well informed on sex matters) to justify the current teaching that parents should undertake the sex education of their children?

In group A, only 7 and in group B, 6 affirmed that the parents are sufficiently free from inhibitions and well enough informed to undertake the sex education of their children. Illustrative replies are as follows:

Dr. J. B. Clark: "When the children who are rightly taught in their childhood become parents themselves, they can safely teach their offspring without fear or inhibitions."

Dr. J. Ramsay Hunt: "Education is best given by the parents, to young children, because it is individual and regulated to the gen-

eral conditions of the child. Most teachers are unmarried and are not well fitted to approach the subject and have not the intimate personal interest or knowledge of the child."

Dr. S. I. Schwab: "I believe that the parents can do this better than any one else—if they are intelligent and well informed."

In group A, 5 individuals returned qualified answers. In group B, 3.

Dr. L. H. Bernd: "The parents should be lectured to and are best fitted for that purpose; otherwise send the individual to a medico who has some tact."

Dr. A. A. Brill: "They are usually incapable in every way, but they are the most logical persons to do it; hence instruct them by competent teachers."

Dr. J. T. MacCurdy: "This is a very difficult question to answer, because I believe that, willy-nilly, the parent is going to be the chief instructor of the child. I am quite sure that it is a most exceptional father or mother who has the courage or ability to tackle the problem directly. Perhaps the best solution could be reached if it were urged upon parents that they should be honest with their children, and it were impressed upon them that their sex relationship (taking the term in its widest sense) is much more open to the inspection of their children than they suspect. With a good example at home, the facts of sex might perhaps be more easily taught by teachers in schools."

Dr. W. C. Quinby: "When correctly informed, parents should give such instruction."

The great majority of the physicians find the parents totally unqualified for giving sex instruction to their own children: in group A, 23 and in group B, 21 answered the question unqualifiedly in the negative.

Dr. T. H. Ames. "No, the average parent does not know *what* to tell, nor *how* to tell, nor *when* to tell; the average parent feels too embarrassed to talk about such matters; the average parent never tolerated masturbation in herself or himself and so cannot and will not tolerate it in the offspring; the average parent cannot be impersonal enough to teach the child."

Dr. J. M. Baldy: "No. Often ignorant, not morally capable themselves, and lack the power to properly convey knowledge."

Dr. S. E. Jelliffe: "Not yet, but they will be and should be the chief instructors—with a free coöperation of wise physicians."

Dr. J. C. Litzenberg: "No, but our efforts should begin by educating parents how to do it. But even then some will be entirely incapable or indifferent."

Dr. G. S. Whiteside: "Not parents of the present generation. Believe the next lot will know more."

In a great many of the answers, a hopeful view was taken that parents are beginning to become interested in such questions and that in another generation they will be able to take care of the sex education of their young.

27. Is the average medical practitioner competent to give sex instruction to children?

In group A, 5 and in group B, 11 individuals affirmed that the physician either is capable of giving such instruction or at least is more capable than any one else. A few replies are given:

Dr. F. L. Adair: "He is if he would give his attention to this matter."

Dr. W. W. Graves: "Yes, but efforts should be made to cause him to be more competent in this direction."

Dr. W. C. Quinby: "Yes. if he should take the necessary time and care."

In group A, 2 and in group B, 2 individuals returned qualified affirmatives. Since this group is so small, no examples of replies are presented.

As in the preceding question, the opinion is prevailingly negative: 29 individuals in group A and 17 in group B unhesitatingly affirmed that the average medical practitioner is completely incompetent to give such instruction.

Dr. T. H. Ames: "No. The average medical practitioner never heard the word sex mentioned in medical school and has never discussed any sex problems with any one. He is himself shocked at mention of the subject. He is not tolerant of a sex emotion as such, but he tolerates the idea of venereal disease."

Dr. L. H. Bernd: "No. As there are few Hugh Youngs or Jeanette Shermans in the profession, the average medico is nearly as unintelligent as the parent, judging from the mass of misinformation some patients receive."

Dr. S. E. Jelliffe: "My experience is that he is a great prude and knows little of the psychology of sex. He has a narrow orthodoxy which is mostly false."

Dr. H. C. Solomon: "I do not believe that the average medical practitioner is any more competent to give sex instruction to children than are the average parents."

28. If these sources are inadequate, what plan of instruction would you recommend?

The answers to this question are so varied and offer so many suggestive points of departure that we quote the majority of the answers in both groups.

Replies from Group A

Dr. E. Stanley Abbot: "The best methods of instruction have yet to be worked out. Facts, not prejudices or assumptions, are needed. The state and national social-hygiene associations may help to solve this problem. Physicians and psychologists may also help. Forel, in his *The Sexual Question*, has given some good suggestions. Prospective teachers in normal schools and colleges should be given sex instruction; social workers, nurses should also be taught how to teach."

Dr. T. H. Ames: "I would recommend education of the physician in medical school, including, in addition to the anatomy of the genital organs (his only instruction at present), detailed physiology of the parts and the deviations from the average physiological and psychological reactions to sexual acts and thoughts. Instruction to the laity must come from physicians, as the laity accredit a certain amount of prestige to a physician."

Dr. A. A. Brill: "There should be courses in psycho-sexuality in every college and university. I feel that sex is important enough to have a department of sexology in every institution of learning."

Dr. Helen W. Brown: "Courses in schools beginning with general hygiene, given perhaps by the school nurse, courses in biology and sociology in which the general facts of existence come out gradually without stupid reserves. The individual sex problems of children should be handled separately by a psychiatrist who knows something of children and sociology. One such psychiatrist might have charge of several schools. He might be also the school examiner for mental troubles."

Dr. Sanger Brown, II: "One plan would be to furnish the school medical examiner with an outline and have it included as part of his duties. If no medical examiner is in attendance, the local health authority. Have it supervised by a visiting experienced physician."

Dr. C. D. Camp: "Either father to son; or, if the father did not wish to do so directly, he could ask an older boy to tell his son what he wished told to him, but without disclosing the source. The older boy should be one who had the respect and admiration of the younger."

Dr. I. H. Coriat: "Sex instruction should be given by properly trained neurologists, psychiatrists, and psychoanalysts, either individually to children brought to them or to small groups of physicians or intelligent parents."

Dr. H. W. Frink: "Very highly trained and carefully selected instructors as a part of the school and college system, whose whole time is devoted to such matters. Similar persons should somehow be made within the reach of young adults who do not go to college. In schools and colleges it would be desirable to have certain members of the classes work as assistants to these instructors and as intermediaries between them and the other students. No perfect plan can be worked out without a good deal of experimentation, but I should think something on the basis of my suggestion will prove to be the ultimate solution.

"I should like to emphasize the necessity for careful selection of the instructors. My observation is that a very large proportion of the persons taking an interest in sex instruction are individuals who have never been able to solve their own sex problems; many of them are abnormal in the extreme and utterly unfitted for the tasks they have set themselves. On the whole, I think it should be demanded that an adult who is to teach others about sex should be unquestionably healthy, and one who has had healthy, wholesome sex experience.

"Books and pamphlets, *properly written*, can be made of much value both to adolescents and adults. However, I have yet to read any which, in my opinion, are properly written or likely to do much good. Sex instruction should not be mixed in with religious instruction, or moral instruction, or with any other purpose or effort at propaganda. To mix in preaching almost always makes the instruction fail of its purpose."

Dr. H. I. Gosline: "The establishment of agencies that have considered all sides of the question involved; physical, social, economic, ethical, religious. At the present time no such agencies exist. At the present time the whole scheme is immature, in my opinion."

Dr. W. W. Graves: "Make sex instruction a part of the education of the individual in the school, starting with the period of puberty."

Dr. T. H. Haines: "Parents must be taught. Schools must take up embryology with a view to teaching sex physiology and hygiene to adolescents."

Dr. R. W. Hall: "The remaining source of instruction is of

course the public school, and I should think this would be very valuable—supplementally. It has the advantage of being uniform and impersonal. It is striking in the neuroses and psychoses how individually many of the patients regard their cases—no one had such a type of sickness before, etc. When they realize that other sick people have been through the same mill, and that, while no two cases are just alike, their type is quite familiar—and especially if similar cases can be described to them—it is striking how they are bucked up. It seems to me this same thing can be applied popularly—in uniform and impersonal presentation. Each one picks out what applies to him and feels that after all it must be a common problem. I don't mean to urge this to the exclusion of a more individual instruction also. Despite our cravings for individuality, the knowledge of possession of some barn-yard herd traits is very comforting at times."

Dr. R. C. Hamill: "Only people who have had to make a study of this question really can adequately deal with it. Also, a great deal of generosity might be included in the attitude of the adult who is trying to help the young."

Dr. Arthur Hamilton: "In my judgment, properly qualified physicians in the community are the best to give this instruction."

Dr. G. V. Hamilton: "Carefully trained nerve specialists, working in coöperation with family physicians. Existing medical organizations could arrange to bring family physicians and nerve specialists together on a safe and convenient working basis. A national board (perhaps the one now existing for that purpose) ought to take account of the fact that there are 'bitter-enders' among nerve specialists who might mistake a lascivious running amuck for emancipation from unconscious inhibitions."

Dr. J. Ramsay Hunt: "Parents should have some instruction in the importance of this, especially women."

Dr. S. E. Jelliffe: "Instruct the physicians first. Then the parents. Few physicians get beyond the false, obvious, superficial, and prurient. They know and tell more smutty stories and are mostly hypocrites regarding sex matters."

Dr. Ernest Jones: "Enlightment by mother at 4, by physiological teacher at 15, by medical specialist later in selected cases."

Dr. J. T. MacCurdy: "I believe that the average teacher is also incapable of giving this instruction, although perhaps better fitted to than parent or general practitioner. I believe that this problem will approach solution only when we have psychiatric clinics in all our schools, where the psychiatrist will be responsible for the solution of these along with other problems."

Dr. H. W. Mitchell: "I know of no plan proposed which would

meet all conditions and indications. Y. M. C. A., Y. W. C. A., and similar organizations might be used as teaching centers."

Dr. Abraham Myerson: "I cannot answer this question. Ideally each child should be instructed separately, but in lieu of this, instruction to groups of boys and girls of the same development should be given by specially trained persons."

Dr. Samuel T. Orton: "If possible, the selection of special instructors for the public schools who are well grounded in biology especially and with training in psychology and psychopathology."

Dr. Charles Ricksher: "That the school textbooks teach sexual matters as other branches of physiology, with no more emphasis than that given to gastric-digestion, for example."

Dr. S I. Schwab: "These are adequate."

Dr. H. D. Singer: "Instruction for parents."

Dr. H. C. Solomon: "I believe that the only really satisfactory method by which this instruction can be imparted is at the hands of a specialist, a person who has made a study of this matter and who feels capable of handling the situation. Ideally, personality comes first into consideration. In other words, the person who is to do this must have an adequate personality. Secondly, medical training or a medical degree is an important attribute. The average child—or adult, as far as that goes—will take this instruction better from a doctor than from any one else. It should be given by a person of the same sex as the student."

Dr. A. W. Stearns: "Carefully selected doctor or others should instruct parents, and parents should instruct children."

Dr. Edward W. Taylor: "A physician specially trained and understanding."

Dr. W. A. White: "Such a specially trained person should be connected with all large educational institutions, and he should by preference be a physician. Every university ought to have at least one adviser for each sex who has a competent understanding of these problems and a sympathetic attitude toward the young in meeting the problem. It would be well if the school physicians could have special instruction in such matters."

Dr. C. C. Wholey: "Place general information applicable to both sexes in textbooks 'Physiology and Hygiene' (and pamphlets). Special information should be delegated to qualified physical-culture teachers or visiting physicians."

Dr. T. A. Williams: "The above agents when possible. When not, by psychiatrists; for the psychic factors are by far the most important."

Dr. G. A. Young: "Instruction in association with school work, beginning in 7th or 8th grade and on through high school."

Replies from Group B

Dr. F. L. Adair: "Some things can be taught in schools directly to children and indirectly through parents. If nurses and doctors would give these matters their attention, much more could be done."

Dr. J. M. Baldy: "One could write a book. I might say that no routine plan can produce results or be advisable for all cases Each individual should be considered by himself or herself, and the environment, education, intelligence, opportunity be a dominant factor."

Dr. L. H. Bernd: "When possible, teach botany and biology in the schools; then, as the children become familiar with these subjects have trained men and women to talk to them of the human functions only enough to make them understand that clean living and health make them better men and women and that the future race depends on them—that a man or woman who does not take care of his or her body is as much a criminal as any other."

Dr. R. C. Bryan: "Fathers for sons, mothers for daughters, classes in high school by reputable physicians selected for the lectures."

Dr. Hugh Cabot: "I have met a moderate number of unusual, very competent people, both men and women. I believe this number is much larger than is realized and that a considerably larger number could be obtained if demanded. They appear to me to be the solution of the difficulty."

Dr. J. B. Clark: "Have well-informed and otherwise suitable physicians instruct all parents (or teachers in lieu of parents) to give the fundamental knowledge outlined in 20 to all young children as early as they can grasp it—and then continue to keep the truth of nature before them. This practice will not hurt the parents either."

Dr. J. H. Cunningham: "Public-school instruction at age of puberty by a real, live, full-blooded intelligent man who knows what he is talking about and talks so that he is understood and believed."

Dr. Hugo Ehrensfest: "Specially trained teachers, men teaching boys, women girls—the teacher trained specifically to teach this as any other teacher is specially trained in his particular branch."

Dr. Ella B. Everitt: "Special courses by medical men and women particularly adapted and qualified to teach other men and women. who in turn can instruct groups and individuals. In each com-

munity specially prepared medical teachers of both sexes should be available for this educational work as a specialty. Small communities should share in the services of one such for each sex."

Dr. F. E. Gardner: "Must be psychological, come from a broad-minded, firm, and disinterested source. I doubt very much whether genito-urinary specialists would be the best agency of teaching."

Dr. J. A. Gardner: "Teachers who have been thoroughly instructed in the subject; should speak before medical meetings, and should address schools."

Dr. R. R. Huggins: "Teach the parents; teachers and ministers may give great aid."

Dr. J. C. Litzenberg: "1. Education of parents how to give the proper information. 2. Education of physicians the same. 3. Special teachers with the qualifications."

Dr. W. E. Lower: "Films, free distribution of printed matter."

Dr. W. P. Manton: "I do not believe these sources inadequate. Certainly such instruction should not be left to old maids or to young unmarried male teachers. If parents are incompetent, it certainly must be a poor community where there is no upright, well-informed physician who can undertake the task."

Dr. W. C. Quinby: "I should use each of these sources and the school besides."

Dr. Jeanette H. Sherman: "Education of parents. Education of teachers. Instruction in connection with school work—not pronounced—gradually taught."

Dr. E. H. Siter: "Matters should be explained to the parents and passed on by them to the children."

Dr. G. K. Swinburne: "I think that teaching 'en masse' is horrible. A boy or girl who is rebellious can readily be instructed, but without the *corps d'esprit* your instruction is a waste of time and the taxpayers' money."

Dr. G. S. Whiteside: "Some medical practitioners (not average) can do it well, some teachers, some Boy Scout masters, some clergymen; not all of any class can wisely teach these things."

Dr. J. W. Williams: "I consider that the method of instruction is most difficult. As most people who engage in it tend to use it for purposes of propaganda, great harm will be done unless such instructors are specially trained, sane, and broad-minded individuals who can inspire confidence and can be relied upon not to go off on tangents."

Dr. A. C. Wood: "Cultivation of a pure mind by precept and example of parents, teachers, etc., clean literature, clean games, clean shows. Avoid lascivious literature, shows, games, etc. Proper education of all functions—do not dwell upon sex as if that were the only function of body."

29. Have you found that adolescents, taught the physiology of reproduction by nature study, apply the instruction adequately to themselves?

In group A, 4 individuals and in group B, 6 gave affirmative answers to the effect that when nature study is properly taught the instruction is carried over to themselves by children.

In group A, 3 individuals and in group B, 3 stated that the material learned is only partially carried over.

In group A, 14 individuals and in group B, 13 gave unqualified negative responses.

In addition to those who did not answer, 17 of the physicians stated frankly that they did not know.

30. What agents, in your experience, contribute most to the first sexual offenses in young men?[1]

The points of view are again so divergent that a fairly complete presentation of the opinions expressed by group A seems the best kind of summary to give. The replies in group B were not in general different from those presented below.

Dr. E. Stanley Abbot: "I have only an impression, as I have no data, but I should say being led into it by companions."

Dr. T. H. Ames: "What is meant by offenses here? Do you mean violent rape of young girls or masturbation? I should consider rape an 'offense;' masturbation an act to be expected in every normal, healthy boy and girl. In any case, the fundamental agent is physiological, the immediate inciting agent is environmental or accidental."

Dr. A. A. Brill: "If you mean legal offenses, my answer is mental deficiency (congenital or artificial). If you mean first sexual intercourse (illicit) my answer is civilization, which defers the mating function too long."

1 The words "sex offense" are objected to in this question by several physicians. In view of the fact that the present questionary was put out primarily for the use of social-hygiene workers, and since they use the term in a purely legal sense, the authors felt justified in adopting their terminology.

Dr. Helen W. Brown: "The tendency to twist and interpret facts and conditions in such a way as to permit one to feel that the thing one wants to do is the right and sensible thing."

Dr C. D. Camp: "Enticement by girls. Imitation of companions."

Dr. I. H. Coriat: "Temptation by others so inclined and a false idea that the ability to perform coitus is the only sign of manhood."

Dr. H. I. Gosline: "Your word 'offenses' shows a bias which nothing I might say could overcome. To maintain such a bias would unfit one for this sort of work. I do not know of any agent which may be said to *contribute most* to the first sexual act in young men."

Dr. W. W. Graves: "1. The sexual instinct. 2. Ignorance of the consequences. 3. Evil associations."

Dr. T. H. Haines: "Alcohol, and male sex offenders."

Dr. R. W. Hall: "1. The 'gang' goes to a house of prostitution. 2. Other boys describe their sexual experiences to him and he emulates them in order to stand up with the herd, and also to gratify his curiosity. I doubt if passion plays much of a rôle at first."

Dr. R. C. Hamill: "Curiosity. The desire to cease masturbation when that act has been represented to them as a potential cause of insanity, loss of manhood, etc."

Dr Arthur Hamilton: "Their own instincts, lashed by lascivious tales of fellows who claim to have led Don Juan lives; the seductions of immoral women; ignorance of the broader issues involved in illicit sexual relations; failures of parents to hold out prospect of early mating, with rewards for continence personal purity, etc."

Dr. J. Ramsay Hunt: "Strong desire and virile nature. Alcoholic indulgence. Late marriage. Immoral associates and removal from home influences."

Dr. S. E. Jelliffe: "Fellow companions; idea of being smart and grown up; servants; and *many married women*."

Dr. Ernest Jones: "Meaning?" (Word "offenses" underlined.)

J. T. MacCurdy: "In my experience masturbation is the most frequent occasion for recourse to prostitution, and I believe that no item of education would be of more value than the knowledge that intercourse without affection is essentially nothing but onanism. In fact, I believe that fundamentally, apart from any economic consideration, masturbation and prostitution are the same problem.

The man-and-mistress situation is, of course, an entirely different affair."

Dr. H. W. Mitchell: "Leadership of elders of both sexes."

Dr. Abraham Myerson: "(1) Counsel and example of older men. (2) The solicitation of immoral women and girls. (3) Special situations such as dances, country automobile trips, etc. However, it may be stated briefly that the urge of desire sooner or later finds an opportunity, which opportunity is conditioned by some of the circumstances given above."

Dr. Samuel T. Orton: "Alcohol and companionship of older men of loose morals, but affable exteriors."

Dr. Charles Ricksher: "Alcohol—curiosity—companions."

Dr. A. H. Ruggles: "Alcohol and prostitution."

Dr. S. I. Schwab: "1. Imitation. 2. Suggestion. 3. Accidental factors. 4. Plays, books, talk, smut of all kinds. 5. Environmental influences. 6. Father's attitude, etc."

Dr. H. C. Solomon: "The most important matter in the sex experience of the average young man is his environment, the moral standards of his associates. Aside from the cases in which he is the passive agent, the crux of the matter lies in the moral standards that are held in his little community. All other matters, I believe, are of secondary importance to this."

Dr. Edward W. Taylor: "Alcohol primarily. Poor companionship. Lack of physical exercise."

Dr. R. M. Van Wart: "The suggestion on the part of others."

Dr. W. A. White: "The causes are multitudinous, but frequently seduction by older persons or at least initiation by older companions."

Dr. C. C. Wholey: "Instinctive curiosity aroused according to the myriads of incidents which might figure in the individual's experience. Probably the most frequent introduction is through some companion who has sex knowledge and imparts the same to the unsophisticated—the desire to be manly, etc. Reading suggestive literature. Insufficient physical outlets and diversions, when once aroused, and overwhelming, driving instinct for sexual gratification, coming in turn from the unconscious drive for procreation, are tremendous factors in continuing offenses."

Dr. T. A. Williams: "Fruits of example."

31. Should any particular age be recommended for marriage, irrespective of economic problems?

In group A, 12 individuals and in group B, 16 answered the question affirmatively, most of them actually giving a particular age. Some merely answered the question affirmatively by saying that they believed in early marriages.

In group A, 21 individuals and in group B, 13 stated that no age could be set. Several members of both groups stated that the matter is so bound up with economic factors that no sensible answer could be returned.

As regard the ages at which marriage is recommended for women, the distribution of answers is as follows: 12 set the proper age for marriage at 20 or over; 5 at less than 20; 2 placed the lower limit as low as 16 or 17. The upper limit for women was 30.

For males all set the lower limit at not less than 20 and all indicated that marriage is desirable in the male before 30 to 35.

III. With Respect to the Material to be Included in a Program for Popular Education Concerning Venereal Disease

32. Should the prevalance of venereal disease be emphasized?

This question was answered overwhelmingly in the affirmative; 27 in group A and 24 in group B stated unreservedly that the prevalence of venereal disease should be emphasized.

In group A, 7 individuals and in group B, 6 stated that, while it should be taught, the facts should not be exaggerated or overemphasized.

Only 1 individual in group A and 1 in group B answered this question in the negative.

33. Should the dangerous character of the diseases be emphasized?

In group A, 24 individuals and in group B, 24 affirmed unqualifiedly that the dangerous character of the diseases should be emphasized.

In group A, 9 individuals and in group B, 5 agreed that the dangerous character should be taught, but not emphasized or

exaggerated. Several of the physicians brought out the fact in this group that serious damage is often done to the individual by stressing the utter hopelessness of such diseases.

Again only 1 individual in group A and 1 in group B returned an unqualified negative.

34. Should the public be instructed concerning the character of lesions resulting from venereal infections, as by photographs of cases?

In group A, 12 and in group B, 18 stated positively that instruction by means of photographs, etc., is advisable.

> Dr. L. H. Bernd: "Especially effective was *Fit to Fight* with the A. E. F."

In group A, 7 and in group B, 4 replied in the affirmative with certain reservations.

> Dr. E. Stanley Abbot: "I believe in telling the layman that the open sore, slow to heal and not apt to be very painful, is likely to be syphilitic. I believe in telling him about snuffles in the baby and about mucous patches in the mouth and nose, but in being careful not to arouse morbid fears at the ordinary 'cold in the head' or 'canker' in the mouth. I doubt the wisdom of showing photographs of skin lesions, as the layman has not sufficient background of experience with other types of skin lesion to prevent his getting a warped judgment."
>
> Dr. H. D. Singer: "Not in detail, but sufficient to lead them to seek advice."
>
> Dr. A. R. Stevens: "Believe in instruction in general, but doubt whether illustrations have added value."
>
> Dr. G. S. Whiteside: "Yes, provided mild and harmless-looking lesions are pictured as well as the most severe."

In group A, 15 replied in the negative and in group B, 9.

> Dr. F. L. Adair: "I think not."
>
> Dr. Helen W. Brown: "The general public probably should not be shown photographs, for they can't diagnose without training. Some might enjoy horrors and others be much upset."
>
> Dr. Samuel T. Orton: "I doubt the advisability of this, as it may lead to efforts at home treatment, etc. Anything which will direct the patient to a good physician, even uncertainty of diagnosis, is valuable."

Dr. H. C. Solomon: "I do not believe that much instruction should be given as to the type of lesion experiences. A layman cannot acquire an idea of specific lesions, and it is exceedingly bad mental hygiene for any one to be looking for a disease. We all know the experience of the medical student and the nurse upon learning of symptoms. I should be rather strongly opposed to this matter of propagating information."

Dr. G. K. Swinburne: "No—decidedly not, or every skin eruption will be taken for syphilis."

Dr. C. C. Wholey: "The use of photographs, specimens, etc.—the kind of thing that would be done with medical students—is to my mind inadvisable in instructing the public, because, not being generally instructed in medical matters, such means of conveying instruction will impart a distorted knowledge of the subject, and morbid ideas and unwarranted fears are apt to result, not only with regard to the subject of venereal disease, but also with regard to other health matters."

35. Are any of these facts (32, 33, 34) likely to lead to morbid fears which would make publicity inadvisable?

In group A, 7 of the answers and in group B, 9 were affirmative, to the effect either that their practice had given incontestible evidence that such instruction led to morbid fears, or that in their opinion it would lead to morbid fears.

Dr. A. A. Brill: "Yes, I have had many such cases."

Dr. R. C. Bryan: "More than corrected by the good done."

Dr. C. D. Camp: "Yes, I have seen a considerable number of such cases."

Dr. H. S. Kretschmer: "Yes. Evidence: the countless neuros who read the ads of the quacks."

Dr. G. K. Swinburne: "I believe that present methods are doing more harm than good."

In group A, 9 and in group B, 7 returned qualified affirmatives.

Dr. A. M. Barrett: "In some instances it may, but this does not counterbalance the good that may be accomplished."

Dr. H. W. Frink: "A campaign intended to produce continence and freedom from venereal disease by frightening young people into morality will not only lead to morbid fears, but to perversions and other abnormal conditions, and would be thoroughly undesirable.

A campaign of truth-telling may have the same effect on some, but this fact, if it is a fact, will be offset by the good done to the many."

Dr. F. E. Gardner: "Yes, but the good outweighs greatly the possible evil. A normal, clean-minded young fellow will not be afraid if he knows he is keeping straight."

Dr. Arthur Hamilton: "Certainly they will, but not sufficiently often to render the instruction improper."

Dr. W. P. Manton: "Possibly in a few instances—morbid, introspective individuals. The majority appear to be frightened into leading clean lives."

Dr. Edward W. Taylor: "In many cases yes—but this does not counterbalance the good."

In group A, 17 individuals and in group B, 14 returned unqualified negatives to the effect either that their practice had shown that when instruction is properly given no such fears do appear, or that they do not believe that such fears will arise.

Dr. J. M. Baldy: "No. Of course an excess of it may, but not such an amount as we are likely to have opportunity to present."

Dr. J. C. Litzenberg: "No, some will be affected, but the majority will not."

Dr. A. H. Ruggles: "Not unless improperly taught."

36. With how much detail should the bacterial, etc. origin and mode of infection be taught?

In group A, 23 individuals and in group B, 4 emphasized the necessity of teaching complete details or at least as complete as the individual can comprehend. A frequent type of reply was that the bacterial origin of venereal disease should be taught with the same degree of thoroughness as that of any other infectious disease.

Dr. H. I. Gosline: "With as complete detail as possible. Such instruction is neutral and has no ulterior motive such as the instillation of fear."

Dr. J. Ramsay Hunt: "The truth may be told."

Dr. Ernest Jones: "Same as other diseases, in lectures on hygiene and physiology."

Dr. W. E. Lower: "Yes, in detail."

Dr. Charles Ricksher: "With as much detail as the teaching of the mode of infection of typhoid fever and tuberculosis."

Dr. Edward W. Taylor: "Considerable."

In group A, 5 and in group B, 15 would teach the bacterial mode of infection, but would not go into details. A great many of these replies called for the barest detail possible or stated that it should be taught only in a general way or in moderate detail.

Dr. I. H. Coriat: "In moderate detail, avoiding medical terminology as much as possible."

Dr. F. E. Gardner: "Not much, just essentials."

Dr. A. R. Stevens: "Believe it is a waste of time to attempt details. That each disease is caused by a specific microscopic organism seems sufficient."

Dr. R. M. Van Wart: "Only suggestions sufficient to enable the student to understand."

In group A, only 7 individuals and in group B, 7 also would give no instruction.

Dr. A. A. Brill: "Altogether unnecessary."

Dr. J. M. Baldy: "Not at all—superfluous."

Dr. E. H. Siter: "Over the heads of most of the people you are trying to reach."

Dr. H. C. Solomon: "The origin of venereal disease from the point of view of laboratory medicine and the like is of little importance to the average man. I think this is merely a matter of cultural information. As one goes higher in the scale of educational attainments, it has a certain general interest, but as far as the ordinary disease campaign is concerned, I do not believe that it has any particular place."

Dr. Edward W. Taylor: "Not worth while."

Dr. J. W. Williams: "As little as possible."

37. Should stress be laid upon the possibility of cure by prompt and continued treatment? . . . Is this likely to lead to overconfidence?

To the first part of the question, 28 individuals in A and 25 in B unhesitatingly affirmed that stress should be laid upon the possibility of cure of venereal disease by prompt and continued treatment.

In group A, 3 and in group B, 4 returned qualified answers, but in general affirmative.

In group A, 6 and in group B, 2 would not lay stress upon the possibility of cure by prompt treatment. Their reason for this is the fear of overconfidence.

In regard to the second part of the question, as to whether the knowledge that the disease will yield to prompt and continued treatment is likely to lead to overconfidence, 7 individuals in group A and 3 in group B answered affirmatively.

In group A, 5 and in group B, 2 returned qualified affirmatives to the effect that if the instruction was well done, there should not be overconfidence, or that even in spite of the fact that overconfidence may arise, the community should protect itself by emphasizing the possibility of cure by prompt treatment.

In group A, 16 and in group B, 17 individuals replied that there is no danger of overconfidence resulting from instruction.

38. What instructions concerning marriage are to be given to men who have had venereal disease?

The replies to this question were almost purely medical and to the effect that no individual should marry until a specialist had issued to him a clean bill of health. In some instances gonorrhea and syphilis were discussed separately. The general drift of the replies may be shown by a few quotations.

> Dr. H. W. Frink: "That marriage is all right if thorough and complete examinations prove that cure is complete. That marriage should never be contracted without such examinations. That those who are not completely cured may, under certain circumstances, and with special precautions, marry, but that they should never do so without *competent* advice. These circumstances and precautions are ones which render the woman safe against infection and children safe against transmission. Unless assurances as to such safety can be obtained from competent authorities, marriage should not be undertaken."

> Dr. W. W. Graves: "If gonorrhea, and a year or more has elapsed, and a competent physician after careful examination finds

no evidence of the disease. marriage may be permitted. If the individual has a syphilitic infection, then for the welfare of the potential mate and children—welfare of the race—the syphilitic should gladly deny himself the privilege of marriage."

Dr Abraham Myerson: "Those who have gonorrhea would need a thorough examination before marriage is permissible. For those who have had syphilis, a thorough course of arsphenamine treatment should be insisted on for at least 2-3 years before marriage is permitted."

Dr. H. C. Solomon: "As to advice concerning marriage to men who have had venereal disease, this will depend largely upon the idea of the physician attending the case. I do not believe that any general laws can be laid down except as very general laws. In the case of gonorrhea, there is no criterion of cure, and yet cure must be the *sina qua non* for permission to marry. This will depend. of course, upon the severity of each case and will have to be left to the discretion of the attending physician. For syphilis the matter stands about the same. Again, there is no criterion for cure. I believe that conservatism, despite the apparent good results of arsphenamine treatment, is advisable, and conservatism, in my estimation. would mean three to five years after infection in those cases which have reacted satisfactorily to treatment."

Apparently the general consensus of opinion is that the men should be allowed to marry after having been given a clean bill of health by a competent specialist. In group A, 2 and in group B, 0 individuals would deny cured syphilitics the right to marry.

39. What attitude toward infected men, presumably cured, is to be encouraged in women?

The answers to this question were very varied as to details, but in general may be classified under one of the following four forms:

1. That in every case the woman should be told by the man before marriage of any history of venereal disease (or vice versa). She should be encouraged to take a sane attitude toward the matter, but to be skeptical of the cure for a reasonable length of time. She should demand a clean bill of health from a competent specialist and then counsel a period of waiting rather than a speedy marriage.

2. That marriage with a man presumably cured is always a risk. She should be told that she may have infected children or weak, unhealthy children, or that she herself may become

infected; in other words, that the man is damaged or belongs in the second-hand class.

3. A large number of the replies stated that if the man were cured, no particular attitude should be encouraged in the woman. Certain of the replies stated that the woman should take the same attitude toward a man cured of venereal disease as she would take toward one cured of any other infectious disease. Many replied that there was no particular necessity for mentioning the matter to the woman at all.

4. That in case the venereal disease had been syphilis, there should be no marriage.

Replies Illustrating 1

Dr. H. C. Solomon: "I should advise what I consider a rational attitude toward men who have been infected and presumably cured. If we feel confident that there are to be no bad results from the disease, I see no reason why it should be held up as of any more consequence than the acts which led toward the disease."

Dr. T. H. Ames: "Proof—i. e., 'I'm from Missouri, show me'—as demonstrated by examination and time."

Dr. W. P. Manton: "Defensive, until a competent physician's written opinion of the cure removes the obstacle."

Replies Illustrating 2

Dr. E. Stanley Abbot: "That she is running a risk of infection and, in the case of syphilis, of having some defective pregnancies; that the man who has indulged in extra-marital venery is not immune from such behavior in the future, even though married to her."

Dr. F. L. Adair: "That they may acquire the disease. That they may have no children."

Dr. H. T. Byford: "Should consider them probably capable of giving infection."

Replies Illustrating 3

Dr. A. A. Brill: "If a man is cured, he is cured."

Dr. J. B. Clark: "The same as towards any other person who has suffered a sickness and may possibly not be a healthy mate."

Dr. A. H. Crosbie: "The same as though he had never had the disease."

Dr. J. H. Cunningham: "*The subject should not be mentioned.*"

Dr. H. W. Frink: "That her attitude toward a man presumably cured should be the same as toward one who had never been infected, except for the fact that she should be urged, and taught that it is her right, to use every possible means that will establish the presumption of cure as a fact. I mean that she should demand full evidences of cure, if they have not been offered her."

Dr. R. C. Hamill: "They are to be accepted, if wanted, if cured as above."

Dr. Charles Ricksher: "Why should they know men were infected?"

Dr. S. I. Schwab: "I should say the same as any other disease."

Dr. J. W. Williams: "That marriage is perfectly justifiable provided the man has a clean bill of health signed by a competent medical authority."

Replies Illustrating 4

Dr. W. W. Graves: "If gonorrhea, and after a sufficient lapse of time and satisfactory examination, she need not hesitate to marry the man. If, on the other hand, the man has had a syphilitic infection, the possibility of acquiring the disease from him, however thoroughly he may have been treated, and the likelihood of becoming the mother of delicate, poor resistant types of children should cause her to refuse to marry the man who has at one time had a syphilitic infection, unless she herself be a syphilitic. Should a syphilitic man and woman marry, then, for the welfare of the race, conception should be prevented."

Dr. G. V. Hamilton: "A man who has had gonorrhea must be pronounced absolutely clean by a bacteriologist. A woman is foolish ever to marry a man who has had syphilis."

The relative frequency of replies was as follows:

Types of replies under 1	28
Types of replies under 2	6
Types of replies under 3	9
Types of replies under 4	3

40. What instruction should be given concerning the use and effectiveness of medical prophylaxis?

1. Thirty-five individuals replied that full instruction should be given, emphasizing the fact that while medical prophylaxis

is not completely effective, it is the best known device for reducing the number of infections per exposure.

2. Twelve replied that instruction should be limited to that given to the men of the United States Army and Navy, or that only enough instruction should be given to avoid suppression—again with emphasis upon the partial effectiveness of prophylaxis.

3. Nine replied that no instruction should be given, that prophylaxis is not safe and not effective.

41. Will the belief in the only partial effectiveness of medical prophylaxis discourage its use?

In group A, 14 and in group B, 5 replied to the effect that a belief in the partial effectiveness of medical prophylaxis would discourage its use.

In group A, 18 and in group B, 23 replied to the effect that if the facts were adequately presented, the belief in its partial effectiveness would not discourage its use.

42. Should self-administration of prophylaxis be encouraged?

In group A, 14 individuals and in group B, 11 stated emphatically that self-administration of prophylaxis should be encouraged; some going so far as to say that, on account of the time element involved, it is the only effective method.

In group A, 5 individuals and in group B, 3 would qualify their remarks in some way—that it "should not be encouraged," that it "should not be publicly taught," that it "should be taught if nothing else could be had," or that "it's better than none."

In group A, 12 and in group B, 14 individuals replied in the negative. The reasons for these negative replies are not given. Usually the word "no" is given without qualification and is sometimes underscored.

43. What proportion of patients infected with venereal disease had an adequate knowledge of the disease before infection?

In group A, 16 and in group B, 15 replied to the effect that few men and no women had anything like an adequate or even

working knowledge of the disease before infection was incurred.

Dr. J. M. Baldy: "Few except second offenders."

Dr. Horace Binney: "Small."

Dr. R. C. Bryan: "But few."

Dr. H. T. Byford: "Not many."

Dr. A. H. Crosbie: "Few."

Dr. H. W. Mitchell: "Few before, and I sometimes think less after."

Dr. J. W. Williams: "Cannot answer exactly, though I know from my experience that a considerable number of educated women scarcely know what syphilis means."

In group A, 6 and in group B, 8 replied to the effect that few or none were ignorant, before infection occurred, of the possible danger.

Dr. J. Ramsay Hunt: "In men, all had a knowledge, not always very exact, of the disease in question. In women many marital cases had no adequate knowledge of the disease or its dangers."

Dr. Ernest Jones: "Most, except knowledge of prevention, which is not accessible to the public."

Dr. J. C. Litzenberg: "Nearly all."

Dr. E. H. Siter: "Males 100 per cent. Females?"

In reading the replies to this question, one is struck by the number of physicians who did not reply or who answered that they were not competent to answer this or did not know. In group A there were 13 such replies and in group B, 5.

44. Is the proportion of gonorrheal re-infections greater or less than would be expected from chance? That is, does one attack of the disease tend to make men more or less careful?

In group A, 12, and in group B, 10 replied that, once having had an infection, the individual became more careful. Many stated that while this is true, it did not lessen the number of exposures.

In group A, 3 and in group B, 5 returned qualified affirmatives, such as, "It depends upon the individual," "It makes some more careful, but some less careful," or, "It makes them more careful for the time being."

In group A, 5 and in group B, 7 replied that one infection did not make the individual more careful.

45. What method have you employed to discourage reëxposure to venereal diseases and with what success?

In view of the fact that this question concerns genitourinary surgeons and gynecologists more particularly than the psychopathologists, the answers received from group B are presented in full.

Dr. F. L. Adair: "Indifferent success."

Dr. J. M. Baldy: "Various. No success at all as far as I know."

Dr. L. H. Bernd: "Taught venereal prophylaxis and the use of protectives, in men. Prophylaxis by smearing the vagina with calomel ointment was suggested to the managers of several houses of prostitution in France, but the result cannot be gotten."

Dr. Horace Binney: "a. Emphasis of danger in contracting disease. b. Results not known."

Dr. R. C. Bryan: "Possible complications; indifferent success."

Dr. H. T. Byford: "Emphasize and explain the dangers of remote effects after supposed cure."

Dr. Hugh Cabot: "I have explained the large probability of increasingly serious consequences and allowed them to draw their own conclusions."

Dr. J. B. Clark: "Stating the facts as we know them has been followed with encouraging results."

Dr. A. H. Crosbie: "I advise abstinence. I give each patient, when cured, complete instruction in prophylaxis."

Dr. J. H. Cunningham: "State the facts regarding the frequency of venereal disease, which shows the odds against one. Appeal to their intelligence in the game of chance. If intercourse engaged, wear condom. If not, prophylaxis."

Dr. Ella B. Everitt: "With women, knowledge of risks they run if they continue to expose themselves to further infection. Married

women who are innocent sufferers may separate from their husbands; others sometimes refuse to cohabit; still others yield."

Dr. F. E. Gardner: "Have always told them very bluntly that the only way to keep out of trouble is to keep away from trouble, and an intelligent youngster, in my experience, is pretty willing to listen to that argument."

Dr. J. A. Gardner: "Have advised prophylaxis, 'sanitube,' with very good results."

Dr. R. R. Huggins: "Emphasize the danger to self and others."

Dr. H. S. Kretschmer: "Not knowing any method that has succeeded, I cannot say. Methods of 'advice,' 'reason,' 'fear' and what not *fail* and are less 'powerful' factors than are:

1. Powers of erection
2. Sexual appetite (in either sex)
3. An attractive and willing partner (either sex)
4. Sex knowledge
5. The time and place.

Dr. J. C. Litzenberg: "Education—plain talks. With what success? I wish I knew; apparently considerable success, but after my 'straight-from-the-shoulder' method, perhaps they go elsewhere when re-infected."

Dr. W. E. Lower: "Presenting possibilities of complication in infection. Do not know with what success."

Dr. W. P. Manton: "Usually men who have had their 'dose' are more careful. Women who are infected by their husbands are usually ignorant of the source or condition. Proper advice to both parties is usually effective."

Dr. W. C. Quinby: "Explanation of reasonableness of continence. Demonstration of damage done by infection. Success depends on position of patient in social scale, in degree of intelligence."

Conclusions

The questionary, giving as it does for the first time a consensus of medical opinion on matters concerning sex education and information about venereal disease, has three general types of usefulness: (1) It should be consulted during the construction of all programs on sex education of both the youth and the adult. It may be objected that medical opinion is only opinion after all. While this is unquestionably true, the various publications of leaflets on sex education have been

based hitherto usually upon one man's opinion or upon the opinions of a very small group. Certainly, in the absence of scientifically gathered data, a consensus of medical opinion should be our best guide in such matters. (2) The questionary in a similar manner should be of aid to those who are undertaking the construction and evaluation of new material —films, literature, etc.—to be used in the various campaigns against venereal disease. (3) It may be used for checking whether the materials, method of instruction, etc. of the films now employed in venereal-disease campaigns are in accordance with expert medical opinion. Again, it may be pointed out that while a consensus of medical opinion as such is not as good a guide for making such evaluations as scientifically determined data, yet in the absence of such data it is unsafe in such campaigns to use facts and information which the majority of medical men would condemn.

Since our own experimental work on the films now in common use is our chief interest, we shall leave the matter of the summaries under 1 and 2 above to those who are especially interested in general sex instruction and in the construction of new campaigns against venereal disease, and confine our summary to 3 above. In attempting this review as to whether the facts and lessons presented by the films now in use in campaigns against venereal disease—especially *Fit to Win*—are in harmony with medical opinion, a sharp distinction should be made between what is presented and what is emphasized: between a proper method of presenting such factual material, and whether *Fit to Win* and the other films employ proper methods and use proper emphasis. Our analysis below is concerned with the types of facts presented and not with the emphasis or with the lessons to be drawn from them. Our experimental work on the films, which will be published elsewhere, deals with the question of emphasis and the evaluation of the methods employed in various presentations.

To make this point especially clear, one needs only to consider an example. The consensus of medical opinion is that the lesions resulting from venereal disease should be presented to the public and that in making such a presentation photographs of such lesions may be used. But whether the method of presentation adopted in, for example, *Fit to Win,*

using as it does photographs of extreme and rare cases of such lesions, is one that would square with medical opinion, or even with common sense, is not touched in our present analysis.

I. As Regards Medical and Biological Facts Taught by Films Such as "Fit to Win"

1. From the standpoint of the emphasis upon the prevalence of venereal diseases and their serious nature, this film, as well as *The End of the Road, The Men's Lecture Film,* and *The Women's Lecture Film,* square with the consensus of medical opinion. In *Fit to Win* a total of 608 seconds are devoted to the prevalance of the diseases and their dangerous character. Question 32 and question 33 in the present questionary receive an overwhelming number of replies to the effect that such emphasis is proper. In regard to the way this information is to be imparted—whether photographs of infected individuals, blind children, cinematographs of cases, etc. can be used—replies to question 34, which asks whether the character of the lesions should be shown by photographs, approve of some such method, since 44 answered in the affirmative (including qualified affirmatives) while only 24 replied in the negative.

2. As regards whether morbid fears are likely to result from the presentation of such facts, there is no consensus of opinion, medical opinion being about equally divided for and against it. Again, as to whether such fears are developed by the films in use, only observation will decide. Our data bearing upon this question will be presented in another publication.

3. In regard to teaching the bacterial origin of venereal disease, the films now in use, especially the *Men's Lecture Film* and *Fit to Win,* are in line with such medical opinion. In *Fit to Win* 30 seconds are devoted to micro-photographs of gonococci and 65 seconds to micro-photographs of spirochetes. Question 36 approves this procedure in the ratio of 57 replies (including the qualified) to 14 against. The film would not have erred, using medical opinion here as the basis of judgment, if more details had been given. The *Men's Lecture Film*

and the *Women's Lecture Film* give much more complete presentations of the bacterial origin of such diseases.

4. On the possibility of cure of venereal disease, *Fit to Win* errs grievously upon the side of suppression of information as to the possibility of cure. Question 37 shows 60 replies in favor of emphasizing the cure and only 8 against imparting such information. While cure is stated as being possible, no facts on the number of persons cured as over against those not cured are presented and no facts on the ease with which most early cases of syphilis and gonorrhea yield to treatment are shown. The impression is studiously created that the man is damaged almost beyond repair. More facts should have been incorporated and more hope held out. Furthermore the film could have taken steps to incorporate a sane attitude in women toward cured men, in accordance with the consensus of opinion under question 39. If more facts had been presented, the film would have been better balanced in this respect.

5. As regards prophylaxis. The facts regarding the effectiveness, limitations, the time limits of application of prophylaxis, etc. are unquestionably inadequately presented from the standpoint of medical opinion. In question 40, 35 physicians stated that the public should have adequate data on the effectiveness and limitations of prophylaxis; 12 replied that the instruction should be limited somewhat—e. g. to that given to the men in the army and navy; whereas only 9 replied that no such instruction should be given—that prophylaxis is not safe and not effective.

As regards the method of applying prophylaxis, the old form of *Fit to Win (Fit to Fight)* gives a good account of the method, showing its actual application by means of the cinematograph. *Fit to Win* gives a very inadequate and meager account of the method, but at least it does emphasize strongly the need, after exposure, of immediate prophylactic treatment at the hands of a qualified physician.

The self-administration of prophylaxis—the important question for the civilian population—is not touched upon. For civilians, medical opinion is about equally divided for and against teaching self-application of prophylaxis. The film, in giving no information concerning this, is probably erring on the safe side.

6. The great lesson in all of the films is that absolute continence is to be insisted upon. The total time in *Fit to Win* devoted to this subject is 453 seconds. It is taught that continence is in no way injurious to health, and that the continent man is equal if not superior to the incontinent. It teaches also that nocturnal emissions are not harmful. While the physiological justification for these teachings (neglecting here all moral and social considerations) have always been assumed rather than scientifically determined, they are in line with the majority of the opinions quoted under questions 16 and 17. The various films, apparently advisedly from the standpoint of medical opinion, do not discuss the question of masturbation or that of sex perversions (question 18).

II. Should Age and Sex of the Individual be Taken into Consideration in the Exhibition of the Films?

1. As regards sex. According to the majority of the replies, none of the films used by the American Social Hygiene Association errs in the inclusion of factual material that should not be shown to the public. Replies to questions 1, 2, 3, and 4 show rather overwhelmingly that both men and women should be taught concerning the anatomy and physiology of their own sex organs, but that there is some question (see replies to question 3) as to the advisability of teaching such facts about the organs of the opposite sex. There is agreement that the general facts of ovulation, impregnation, development of the embryo, etc. should be taught. In venereal-disease campaigns, especially where motion pictures are employed, these questions arise only incidentally, but in showing methods of the contraction of venereal disease, the spread of infection from the various foci, the infection of the embryo, etc. such details must necessarily appear. This is especially true in the *Men's Lecture Film* and in the *Women's Lecture Film.* Few such details are shown in *Fit to Win.* The question as to whether these films should be shown to mixed audiences introduces social factors which are not touched upon here, but which will be discussed in our other publication.

That there is a possibility at least that certain parts of the film may inculcate in women a reaction against all sex relations should be borne in mind. Replies to question 10 show about an equal division of answers for and against the possibility that maladjustment in married life may result from women's belief in the obscenity of all sex relations.

2. As regard the age at which such films may be seen: the films when considered purely from the standpoint of the material presented—leaving aside the question of emphasis, that of the dramatic method employed, etc.—present no medical or biological facts that should be kept concealed from boys and girls who have entered puberty, provided we assume, in accordance with the consensus of medical opinion under question 21, that the facts presented by the various films have already come within the child's own experience. According to the opinion expressed under question 24, even the existence of prostitution should be taught at puberty, there being 29 affirmative replies as over against 17 negatives.

Probably the physicians returning these answers, judging from the whole series of replies under II, would insist that before such a presentation of material could be assumed as being safe, the adolescent should have had gradual education in sex matters from early childhood to puberty at the hands of properly qualified parents or other instructors.

AN OUT-PATIENT CLINIC IN CONNECTION WITH A STATE INSTITUTION FOR THE FEEBLEMINDED *

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A MODERN institution for the feebleminded, with its trained personnel, its diagnostic facilities, its highly specialized equipment for training and education, with a vast background of experience, covering the completed life histories of many mentally handicapped individuals, constitutes a civic asset, with exclusive opportunities for individual application, which should be freely available, not only for the relatively few persons who are committed to the institution, but to all citizens of the state who need such services.

In practice, in all such institutions, it has been found that problems of juvenile and adolescent mentality and of maladjustment arising in the institution territory are frequently brought to the institution for advice. Thus, an out-patient clinic naturally develops to a greater or less extent as a part of the work expected of a state institution for the feebleminded. This is not only greatly to the advantage of the community, but it is a great privilege and opportunity for the institution staff to be brought into contact with many undiagnosed juvenile mental and personality problems.

At a time when mental clinics are rapidly being organized all over the country, it may be of interest to describe briefly the practical working-out of the Waverley clinic.

The Massachusetts School for the Feebleminded has been established for seventy-two years, and is located within thirty miles of the homes of two million of the three and one-half million inhabitants of a relatively small state with excellent transportation facilities.

In 1891, the number of outside cases applying for advice had so increased that one day of each week was designated as

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out-patient day, and this practice has continued to the present time, although cases are also often seen on other days. This plan is generally understood by neighboring physicians, social workers, etc. It is also generally understood that advice may be sought freely by letter or telephone at any time. No charge is ever made for advice given at the school. Over six thousand patients have been referred since 1891.

For several years past, from five to ten patients are examined on each out-patient day. A larger number could not be handled with present facilities.

The staff of the school also conduct regular mental clinics in connection with the public-school organizations in Worcester, Fall River, New Bedford, and often in other cities. Many other cities desire similar school clinics. An augmented staff recently examined 41 presumably defective children in one day in a rural school in a degenerate community.

For the year 1919, the clinic at Waverley gave advice concerning 377 patients. Of this number 280 were thoroughly examined and the others were advised by letter or telephone. The number was much smaller than for several years past, as the clinic was suspended for some months on account of influenza and quarantine for influenza.

Social workers referred 89 cases, physicians 75, parents 69, school officials 36, hospitals 24, courts 17, etc.

Cases were sent from 63 different towns and cities, a majority of the cases living within thirty miles of the school. Thirteen states other than Massachusetts sent one or more patients. Four came from Canada, and one each from China and the Canal Zone.

The cases came from various social levels, and on the whole represented a much higher social and economic status than do the average institution inmates. The very fact that advice was sought implies superior average intelligence on the part of the parents.

The chronological ages of the patients were as follows:

Under 1 year	1
1-2 years	14
3-4 years	29
5-9 years	83
10-14 years	105

15-19 years	65
20-24 years	23
25 years and over	19
Age not stated (letter or telephone cases)	38

The largest number was at the 10-14 year period.

These cases come to the clinic because they present problems of some sort. The people who bring them want not only a diagnosis, but a prognosis and explicit advice as to treatment and management, often for many years in the future. We have found that worth-while advice must be based upon the most complete knowledge and understanding of the patient—his bodily constitution and make-up, his heredity, environment, clinical and developmental history, school record, pedagogical measurements, capacity for family and social adaptation, the presence or absence of innate or acquired character or personality complexes, and the results of a thorough psychometric examination.

In practice, it has been found that the significant phenomena of juvenile and adolescent problems may be assembled in certain consistent groups. The following ten "Fields of Inquiry" furnish a working basis for individual case study:

1. Physical examination
2. Family history
3. Personal and developmental history
4. School progress
5. Examination in school work
6. Practical knowledge and general information
7. Social history
8. Economic history
9. Moral history.
10. Psychological examination

A special syllabus for each field of inquiry has been developed, each on a separate sheet.

A satisfactory examination of a given case requires from one to four hours. The examination is a matter of highly specialized teamwork. The psychiatrist makes the physical examination and measurements and develops and records the clinical and developmental history. A teacher verifies grades reached in school and definitely measures and records present scholastic capacity and general knowledge. A trained social worker investigates the economic history, the social history

and evidences of character defect, and immoral or criminal record. The psychologist gives a thorough psychological examination. A nurse is always present. The patient is passed from each examiner to the next one in turn. Each examiner fully records the findings on the appropriate single-page record sheets. A secretary condenses the significant facts on a separate "Synopsis of Findings" sheet, classified under the ten separate zones or fields of inquiry; which, with the detailed record sheets, accompanies the patient to the chief of the clinic.

The patient is then independently examined by the chief of the clinic, before he has read the history as gleaned or the story of the patient's friends has been heard, and the result of his examination is compared with the previously recorded findings. In a long day's work, this procedure is much more stimulating and interesting than to examine a patient whose history already has been read or heard. It also inhibits the natural tendency to be unduly influenced by the findings and impressions of trusted associates—a wise precaution for a properly suggestible clinician! Incidentally, it evolves a variation of clinical technique which minimizes the disadvantages of any more or less routine diagnostic syllabus.

The synopsis sheet is then evaluated, field by field, a minus (—) sign put opposite the fields presenting evidences of defect or disease, and a plus (+) sign opposite the fields with no such evidence.

The case is then ready for diagnosis. Each case is afterwards carefully reviewed in detail by the entire staff.

The diagnostic significance of the findings in the ten fields of inquiry has been described in previous papers by the writer. If the case is one of uncomplicated mental defect, a majority or all of the fields will have a *minus* sign. A preponderance of fields with *plus* signs usually means something other than straight mental defect.

The findings in the different fields have an enormous significance, not only as to diagnosis, but as to prognosis, treatment, training, and future life history. A mere diagnosis of mental defect, or statement of mental age or intelligence quotient, is not a basis for intelligent prognosis or efficient treatment and education.

The diagnoses in the 377 cases for 1919 were too individual and complex to be satisfactorily shown in a statistical tabulation, but the following primary groupings show the wide range of patients coming to such a clinic:

Feebleminded	93	
Feebleminded and delinquent	101	
Feebleminded and insane	6	
Feebleminded and beginning psychosis	3	
Feebleminded and epileptic	2	
Feebleminded and probably epileptic	2	
Feebleminded and hysterical episodes	4	
Feebleminded and syphilis	4	
Feebleminded and cretinoid	2	
Feebleminded and other dominant endocrine symptoms	4	
		221
Inferior normal, maladjusted or with character defect	14	
Normally minded, maladjusted	19	
Normally minded, delinquent	9	
Normally minded, dullness, caused by adenoids	4	
Normally minded, spastic	1	
Normally minded, deaf mute	1	
		48
Superior normal, maladjusted	2	
Superior normal, developing psychosis	1	
		3
Psychotic	20	
Developing psychosis	8	
Psychopathic	6	
Developing psychosis and delinquent	1	
Epileptic	7	
Probably epileptic	1	
Psychoneurosis	2	
Neurosis	2	
Constitutionally inferior, maladjusted	6	
Constitutionally inferior, with hysterical episodes	1	
Diagnosis deferred, for further study	19	
Diagnosis deferred, child too young	7	
Diagnosis deferred, child refused to be examined	1	
Diagnosis deferred, letter or telephone message gave insufficient data	24	
		105
		377

In many or all of these cases, a merely psychiatric or psychologic diagnosis was not sufficient. The individual diag-

nosis, to be pragmatic, must take into account the bodily condition, heredity, home conditions and the whole environment, learning capacity, mental symptoms, social adaptability, economic status and earning capacity, character and personality traits, intelligence level, and other psychological ratings. The mere name of a disease does not get us very far. This is as true of the feebleminded cases as of the frank psychoses and the various other phases of maladjustment.

The advice given is infinitely varied and often of many dimensions, in accordance with the diagnostic findings, viz: institution care; home care; special class; private school; private teacher; change of school; change of teacher; let up school pressure; take out of school and send to work; change of work; treat as delinquent; special medical or surgical treatment; country life; travel; vocational training; add new interests and recreation; place in selected family; modify home environment; etc.

In nearly every case the fact is stressed that the patient is capable of only partial efficiency in any field, perhaps 40 or 60 or 80 per cent of the average, and that more must not be demanded, that he will often need to be put on his feet, but that he will eventually find a level where he can live comfortably and happily.

The majority of these problems do much better than we expect them to do.

With the feebleminded cases, if the home is a good one and the patient suitable for home care, the parents are carefully instructed as to training and management, given helpful literature, and are asked to return the child once or twice a year for further advice, if necessary.

Some of the parents make several or many visits to observe training and nursery methods and obtain further help. Others write many letters for this purpose. The prospects for successful supervised home training of many cases of feeblemindedness is not generally understood. Many parents will never send their mentally defective children to an institution. For years to come, the great majority of such children will receive all their training and care at home. Each patient cared for at home means a saving of $300.00 per year for maintenance and $1000.00 or more for institution construction.

One hundred and one feebleminded cases apparently needed institution treatment for medical and personal care, because of bad habits, vicious tendencies, or home insufficiency. As many of these as possible were admitted to the institution—the helpless, those from overburdened homes, those with pronounced character defect, those from highly potential hereditary stock, those with sex promiscuity, and as many as possible of the young morons who would not receive proper training at home. This clearing-house opportunity of the clinic is full of possibilities.

Many of the group apparently needing the institution care were also quite amenable to change of environmental conditions, such as the letting up of useless school pressure, relief from too exacting home conditions, too little occupation, too little recreation, bad associates, etc. Far too much has been expected and demanded of these inefficient people. A clear demonstration of the patient's limitations and his tendencies often enabled the guardian to manage him well at home.

We have been advising the friends of some of these cases for many years. Some return annually for advice and some only when the patient again gets into trouble.

It is a striking fact that of the thousands of cases diagnosed as feebleminded at this clinic since 1891, the majority have not subsequently applied for admission and are not known to have seriously misbehaved.

A well-marked-out plan of after-care, with regular visitations, would be very welcome to the parents and would be of great value. As it is now, we are advising more patients under home care than are being cared for in the institution itself.

Advice was sought in seven cases as to the advisability of adoption; in four cases it was advised and in three disapproved. In two cases the advisability of marriage was in question; in one case it was approved and in the other advised against.

As to the inferior normals, almost without exception we were able to make them happier and better off by easing up the standards of achievement in school, in social life, or at work that ambitious guardians had expected them to live up to. Too much had been expected of them also. One boy of

nine, with an eight-year mind, was most incorrigible in the fourth grade in school, but when dropped back to the third grade, his badness disappeared and he became happy and contented.

The maladjusted normals, it was often found, were bored by their studies in school, or were nagged by neurotic parents or otherwise misunderstood at home, were at work at uncongenial tasks, or did not have the necessary variety of interests and recreations.

Several children, most incorrigible under home conditions created by parents with no understanding of the primary needs of childhood, promptly began to behave properly and normally when taken from home and placed in a selected family with wise management. In a surprising number of instances the real difficulty was not with the child, but with the parent or parents.

Two "superior normal" boys, in court for repeated truancy and theft, became at once obedient and "biddable" when they were given interesting school work appealing to their superior intelligence and given an outlet for their craving for adventure by a summer in a boys' camp and free access to properly exciting boys' story books.

Many of the juvenile delinquents seemed to be merely expressing their dissatisfaction with the limited opportunities afforded by city life for the normal self-expression of boy and girl interests. Here we tried to replace the previous plan of taboo and repression by constructive substitution of attractive and interesting play and occupation, often with prompt and happy results.

One girl of fourteen, fully matured physically, with a normal mind, and with an over-puritanical mother, was not allowed to play with other girls of her age or to read any books or have any recreation whatever. She became truant and sought sex expression as the only possible adventure within her reach. A prescription of pretty dresses, girl friends, daily browsing in the public library under wise guidance, books and papers at home, etc. afforded normal expression for the intellectual and emotional interests of this "little woman who had been treated like a child," and her misconduct at once disappeared.

Very rarely is the reformatory recommended for a juvenile delinquent with a good home.

Dementia praecox is the form of psychosis usually found in these adolescents. In most cases the nature of the disease had not even been suspected, and the patient had been treated with severity and harmful discipline. A change of environment, a variety of new and simple interests, and a sympathetic understanding of the patient, sometimes brought about a temporary comfortable adjustment. Several of the dementia-praecox cases voluntarily returned several times, saying that they "felt better after talking things over." Of course the majority of the psychotic cases were referred to the state hospitals for proper treatment.

The pre-psychotic and probable pre-psychotic cases are of great interest. They are seldom seriously regarded by the family physician. They are not usually seen by the psychiatrist at this stage. They have generally shown suggestive changes in their ways of thinking and feeling and behaving. We do not yet know the danger signals of the school period as portents of future mental disease. All of our youthful pre-psychotic cases were culled out of school by some discerning teacher or parent for some failure of adaptation, and not as mental cases. None of them were referred by physicians.

A majority of the cases seen here were of public-school age. A study of the mental or personality problems appearing in any high school or college for a decade would yield rich material in this field of preventive medicine. This could only be done by a special public-school clinic, so informal and sympathetic and helpful and human as to invite and encourage boys and girls to talk over frankly their problems of adjustment and adaptation—problems really as old as the human race, but to the boy or girl terrifically new and appalling.

This school clinic should make available for our children in the public schools at the time they need it most the knowledge and experience of skilled and seasoned psychiatrists, neurologists, and psychologists. The clinic should have no connotation of the diagnosis of actual mental disease or defect. Cases of developed mental defect or insanity should be diagnosed and handled under different conditions.

EXTENDING THE FIELD OF CONSCIOUS CONTROL*

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BARBELLION in his journal said: "There are people who have seen most things, but have never seen themselves walking across the stage of life. If some one shows them glimpses of themselves, they will not recognize the likeness." This is not only true of "people who have seen most things," but is equally true of the much larger proportion of people with a more limited range of vision. No matter how broad and deep our knowledge may be, it may not and usually does not include, in any true sense, a comprehensive understanding of our own intimate selves. That we all have an intimate self is a commonplace, but like so many commonplaces—time and space, the twinkling of a star—does not bear examination; at the first question, almost, recourse must be had to evasions and subterfuges, for the fact is we are not really acquainted with it. It is only since the rise of the new psychology—a very few years—that we have come to any orderly understanding of this inner self of ours and have learned how to question it and discover its characteristics. This knowledge grew, in the first instance, out of the necessities of the consultation room, as the old methods were found increasingly less satisfactory for estimating the patient's condition by what he was pleased to volunteer regarding it, by accepting his explanation of his nervousness, sleeplessness, lack of interest, and then prescribing more or less at his dictation—rest, a trip abroad, perhaps an operation. It took a long time to discover the obvious in this department of medicine and to learn that the patient's symptoms had a meaning that could be discovered by effort aimed in the right direction. When this was found out, it also appeared that the treatment—the trip abroad, for example, which had been slyly suggested by the patient and gratefully caught up by the physician as an easy way out of

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a difficult situation—was desired by the patient, and the doctor had been used only as a convenience, and because of his authority, to obtain it. The nervousness, the sleeplessness, the lack of energy, and all the rest of it could now be seen to be the natural results of an intolerable home situation, for example, and the trip abroad a pleasant means of escape and perhaps in addition a means of punishing a recalcitrant member of the family. In all of this complex medley, the patient may be serenely unconscious of what it is all about, and is being used by unconscious instinctive tendencies and, besides, is victimizing all about, family and physician as well. With this type of conduct we are all quite familiar. Just so soon, however, as we come to examine conduct broadly with the object of determining its meaning—when we come to inquire why people behave in this or that way, what object they have, what return they get from what appear to be inconveniences or even illnesses—then we begin to realize how widespread are these types of behavior reactions which are produced in response to instinctive demands that remain unconscious, unknown to the individual.

It seems obvious, when the problem is stated in this way, that the only possible way to remedy such a state of affairs is to bring the motive of the individual into the field of consciousness as a preliminary step at least to changing the behavior. Whether improvement can or cannot be wrought in conduct, it must come about, if at all, by first enlarging the field of consciousness to include the tendencies back of the conduct in question, and then control and a redirecting of energies may be effected if possible. So long as the motives for conduct lie wholly without the field of consciousness, so long is the individual their creature instead of their master. This, in brief, is what is meant by extending the field of conscious control; it is the principle at the basis of the psychoanalytic approach to the psychotherapeutic problem, and its validity is witnessed to by numerous successes in this field as well as by the facts of development. I mention only in passing the gradually increasing control of the functions represented at the thalamic level by the cortex in the evolution of the cerebrum, the efforts made by education to the same end in the development of the individual, and the various political gestures calculated to render the voice of the people audible; no

example could be more striking than the present effort throughout the world to make the forces let loose by the war available for the ends of peace, and I think you will agree with me that the principal difficulty in doing this arises from our lack of knowledge of the real nature and extent of these forces.

Just a few illustrations of the way things may go wrong because of the unconsciousness of the motives actuating conduct. A teacher, for example, in starting with a new class, is convinced that one of her pupils is stupid and vicious. The reason for this opinion is traced to his resemblance to a former pupil who was in fact vicious and stupid, but the associations have dropped away from consciousness and only the prejudice is left. It is obviously important that the teacher's field of consciousness should be enlarged to include these lost associations if the pupil is to get fair treatment and attention commensurate with his real qualifications.

A most common way in which unconscious tendencies lead astray is by the projection of a wish. An associate is perhaps rather a dangerous business or professional rival. It would go a long way towards clipping his wings if it were generally known that he was dishonest. Such a suggestion creates the wish that he were dishonest; the wish is believed in because, if true, his dishonesty would react favorably; and as a result the conduct is in accord with the belief, and actions and statements begin to cast suspicion upon his honesty. This is in part the subtle psychology of rumor and is a mechanism we have seen used over and over again in recent months by the nations at war in working up their hostile feelings toward erstwhile friends, but present enemies. This was the sort of psychology or mental mechanism that was so universally prevalent in the Middle Ages and that made anything like a scientific approach to the facts of reality impossible because of the warping effect of an all-enveloping egocentricity which viewed the universe with man as its center and all else created to minister to his needs. Things were seen as they were wished to be, not as they were. "Eyes and ears are bad witnesses to men who have not an understanding heart."

The conquering of our environment is made possible only by an increase in our knowledge of that environment, which is, speaking in general, accomplished by a process of becom-

ing conscious of the things that constitute the environment and of the laws that govern them. But this is a different aspect of the enlarging of the field of conscious control from that with which mental hygiene concerns itself. Great advances in our knowledge are made possible, among other ways, by the perfecting of the instruments with which we examine the environment. In the course of evolution the perfecting of the sense organs has brought the higher animals into contact with aspects of the environment unknown to lower forms, while in the realm of science the perfecting of instruments for enlarging our perceptions has been a notable factor in bringing a constantly wider aspect of the environment within the realm of our perceptions. The perfection of the microscope, the telescope, and the spectroscope are instances in point, and this perfection of the instruments for increasing the field of our perception has, among other things, been along the line of correcting imperfections which produced erroneous results. The process of the elimination of defects has taken place at once in the realm of organic evolution—for example, the correction of the defect in vision produced by the blind spot of the retina—and in the fabricated instruments for enlarging our perception—as, for instance, the correction of errors of chromatic aberation in the microscope. Now the human mind may profitably be considered as an instrument for contacting with the environment, and it is equally important to look to its sources of possible error with a view to correcting them. This was early appreciated by the astronomers, who found that a series of observations of the same phenomenon were not all alike. The human machine did not function with absolute accuracy, so that an allowance had to be made for personal errors in correcting the observation—the so-called personal equation.

The new psychology has discovered the same sort of thing with reference to man's conduct, his beliefs, activities, observations, and his estimates of his fellows—in fact, his whole field of relations to his personal and social environment. An individual's reaction in any particular situation is determined not alone by the factors of the situation itself, but by the sum total of his previous experience which relates him to it and of most of which he is quite unconscious. In other words, we approach every situation with a certain personal bias—

a prejudice, if you will—based upon what the particular nature of our previous experiences may have been. For example, we subscribe to certain religious, political, social doctrines, choose our profession, our recreation, our friends, elaborate our theories of living, our philosophies, almost altogether because of tendencies that lie back of consciousness and of which we are only vaguely, if at all, aware. In other words, we approach all our problems of living with a bias, a prejudice, born of the unconscious, and our lives express, among other things, our reactions to these unconscious urgings. It is a matter of common knowledge that often our tendencies are at variance with our own as well as others' interests, but never before has there been an adequate appreciation of the nature of the problem of bringing these tendencies under control and direction, much less a technique for doing so. This is precisely what the new psychology essays, and because of the tremendous importance to mankind of the problem it attacks, its suggested solutions must receive an adequate hearing.

Mental hygiene, therefore, has to do with a refinement of this instrument of ours, the mind, so that it will work better in its function of relating us to our environment. To that end it is essential to know it through and through for what it really is, so to speak, rather than to take it at its face value. Just because a man says so and so, even though the man be, as a matter of fact, truthful, is no reason why we should accept his statement. A man tells us that he really does not care for alcohol, that he takes it only as a matter of sociability, and he may think he is telling the truth, but we watch him year after year becoming a confirmed alcoholic and we know that it was not so. In truth "actions speak louder than words."

Such a man, however, may easily have fooled us into an acceptance of his statement, but more important still is the fact that he succeeded also in fooling himself. For, after all, the essence of mental hygiene is self-knowledge, for we must first be honest with ourselves if we are to succeed with others. "To thine own self be true. . . . Thou canst not then be false to any man."

Our instincts are bound to get expression in some way, sooner or later, and if we are not capable of understanding their promptings, then they gain expression by some devious

pathway and parade as something that they are not. An instinctively cruel person might be attracted to work requiring animal experimentation or, on the other hand, might succeed quite as well in satisfying his instinct by occupying his mind in imagining all sorts of fearful horrors associated with such experimentation and become a rabid antivivisectionist. In both cases he is more apt that not to do great harm because he does not approach the problem with a balanced mind, but is more intent upon the emotional satisfactions he will derive from the contemplation of suffering than upon the furtherance of certain researches in the first instance or the doing away with suffering in the second. If we would lead well-rounded lives, we must be able to bring all of ourselves to the problems we have to deal with and not have our efforts dammed by a divided allegiance. That we may do this we must know ourselves, and knowing ourselves means an ever-increasing field of ourselves over which we may extend conscious control.

As physicians we must no longer be content to leave the personality out of the scheme of our attempts to understand illness, for if our theories of the nature of the human psyche are correct, then the mind is the central station, the clearing house for all the activities of the body, and so every physical symptom must have its reverberation in the mind of the patient, and many of them cannot be adequately understood unless we take into account the psychic factors involved. This means that we must no longer be content to take the patient's account of his symptoms as final, any more than we accept a cough as final and neglect to examine the various organs—lungs, heart, larynx—for its explanation.

When it is once generally recognized that mental reactions are as definitely determined and as reasonable as physical and physiological reactions, there will be a decided step forward in the enlargement of the field of conscious control.

We need not concern ourselves seriously about the environment. An increased knowledge of it and its laws and the bringing of it more and more under control is the prominent fact of our civilization. During all this period of what has been called the evolution of our environment, man has himself evolved, and that evolution has been, among other things, the result of an ever-increasing extension of his field of conscious control as I am using that term in this discussion, or, speak-

ing in more usual terms, an increase in the capacity to bring the instincts under the domination of the intelligence. This is of course the evolution I am talking about, but in the past it has been accomplished unconsciously and only incidentally, as it were, in the attempt to attain other ends. In order, for example, to attain to a position of eminence and power in the community, one had to forswear acts of violence and injustice. The instincts had to be restrained, but that restraint was not an end in itself, but only incidental to an entirely different conscious purpose. But now the program of mental hygiene means the conscious pursuit of that which has heretofore been only an incidental goal, the intelligent attack upon the problem of how to bring the instincts into the best service to the individual—how to run them and so ourselves instead of being run by them. This awakening consciousness of man of himself is a new instrument of civilization, a new tool, if you will, which man from now on will use to fashion his destiny or until at some time in the future another shall come to take its place.

Think for a moment what it would mean if the principles of self-knowledge were once generally known, if each man's little dexterities calculated to deceive were capable of instant interpretation by his fellows. Suppose, for example, the chronic grouch who is always finding fault with everything and everybody should realize that he is only advertising his own incompetence, and suppose all his fellows realized this. See what a difference it would make to the man himself—how he would restrain his complaints and have the energy he would otherwise dissipate available for use on the job. This would increase his efficiency, make him more successful and so happy, and thus end the occasion for the grouch. At the same time his employer would not have to waste a lot of time trying to verify his stories of how the other workmen used him badly, but would know at once where the fault lay and could at once proceed to bring to bear his influence in correcting it without having wasted much energy on the way and without having obtained a lot of erroneous opinions about his other employees. The whole process, without elaborating further, can be seen to make for efficiency by a better understanding of the conditions as they really are, and consequently for a greater capacity to meet them effectively. With this

new understanding many problems that exist for us to-day will cease to be because the misunderstandings that have brought them into existence will be swept away. For example, subtle distinctions between simulation, malingering, and hysteria can have little practical significance when we realize that their only difference lies in the degree of conscious purpose with which the patient utilizes his symptom, and that the problem is not whether we may find justification for condemning, hating, and punishing the offender, but whether we can deal with the situation so as to improve it. By projecting our own antipathic tendencies into the situation, we blind ourselves to an all-round vision of the possibilities, and fail in consequence to get the best solution.

I cannot refrain from making reference, at this point, to another series of problems that will receive a most important illumination by this approach to the problem of illness. I refer to certain physical ailments which at present are most baffling to our understanding. I do not here refer to various functional disorders of sensation and motion, the anæsthesias and paralyses that have been recognized for so long as of hysterical and therefore psychogenic origin. This group includes a host of symptoms in every department of medical specialism, such as paraplegias, tremors, spasms, aphonias, amblyopias, deafness, the so-called false gastropathies and cardiopathies, all sorts of neuralgialike reactions, emotional tantrums, in fact almost all conceivable types of symptoms with which every practitioner is more or less familiar. I refer rather to various conditions that come more nearly within the conception of organic disorders, but that may well at first be purely functional. If we view the human machine as a whole, we must realize that its several parts must serve the ends which it as a whole is endeavoring to accomplish. If, therefore, the individual approaches the problem of his life with a divided interest, he must of necessity be constantly utilizing his energies for different, often mutually opposed, ends. The result will be that the machine will be set for certain types of reaction which are not permitted to come to pass. These motor sets of the organism will produce tensions of the musculature, voluntary and visceral, as well as psychological tensions which, when long-continued or severe in character, tend to break down the machine. An example of

the acute type of this sort of reaction would be the development of gastric ulcer in soldiers of the front line kept for a relatively long time under the tension of extreme anxiety awaiting an expected attack. An example of the more chronic type would be a chronic glycosuria from the constant inadequately reacted to emotion of fear. Many other examples suggest themselves, but I would only indicate the possibility that we may find by this method of approach better explanations of such well known problems as are presented by the many chronic illnesses which affect the overworked, overworried, harassed man of affairs. Energy that is used in the service of repression, to use the psychoanalytic terminology, shows itself in the friction with which the machine works and the consequent wear and tear of its several parts.

The reason why I am so sanguine for the future of this new movement is because the facts that have been worked out regarding man's psychic structure involve him in his profoundest parts and point clearly to the direction in which we must look for improving his personal and social relations, for a constructive attack upon the problem of education, and for the illumination of innumerable social and therapeutic problems. And the place where a beginning has been made and from which an influence will continue to spread is the consultation room, where the physician undertakes as careful an inquiry into the personality make-up as into the bodily structure. And the way to begin to accomplish something in this direction is not to wait until one has acquired a profound knowledge of psychology, but simply to approach the problems free from prejudice and with the conviction that psychological manifestations are facts that are as susceptible of explanation as are physical states. Then when the new way is known, it will show how education may become a process of unfolding rather than repressing and will teach us where to look for our defects in character. Man has always been inclined to project all his interest outside himself, and this new viewpoint will teach him not only where he may expect to find the origin of the trouble, when trouble there is, but also the method of unearthing it—and so bids fair to become at least as important a means for progress as, for instance, the invention of the cotton gin.

Evolution does not alone take place by a gradual, slow, uniform progress in some given direction, but by mutations, by saltatory advances, by the sudden creation of something new, something different. These sudden departures from the average are the real creative moments of evolution. They stand for a new method, supply a new instrument for dealing with reality, and from them as starting points evolution proceeds rapidly until the possibilities of the new instrument have been pretty well exhausted; then evolution slows down, perhaps comes almost to a standstill, until nature gives birth again. Such new instruments, which have made the present estate of man possible, are the prehensile hand, language, self-consciousness. I look upon the new psychology that teaches that we must turn our vision within—that consciously attempts to correct the error there rather than always see it without—as a new method, a new instrument with which to attack the problem of living. It matters not that we have always been moving in this direction; the great new fact is that we are now beginning, for the first time, to do so consciously. The possibilities are endless, and particularly at this wonderful time in the history of culture, when civilization has been tried to its utmost, is it important that the structure which shall be erected from the primitive forces that have been loosed shall be a better one than has ever before been builded. To do this we need to be able to brush away the distortions wrought by our unconscious, to see through them all down to the very depths, to see the real problems and not waste our energies in tackling false substitutes. A realization of the mechanisms by which such distortions are produced, by which the mental machine may fall into error, will help us enormously to see clearly, will extend our field of conscious control. This is the true self-consciousness. "Open covenants openly arrived at" is quite as good medicine for the individual as for the state.

THE MENTAL HYGIENE OF INDUSTRY

Report of Progress on Work Undertaken Under the Engineering Foundation of New York *

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A MOVEMENT for a mental hygiene of industry is taking shape and making progress. A year ago one could hardly make this statement with confidence. The idea of improving the mental condition of industrial workers through medical science was thought to be hopelessly vague. Neither the practical industrialist nor the theoretical psychiatrist was expected to concede that it would be possible in big industrial systems to give attention to the mental health of employees, or to be persuaded that practical plans for meeting industrial unrest must be built up from the bottom—that is, upon the individual worker. A few years ago the most that could be said was that there were widespread signs that the subject was beginning to receive attention, and now and then an emphatic call to meet the problem. At the present time, the literature of industrial management is full of the need for scientific methods of dealing with minds as well as materials.

As in all new movements, many influences of independent origin have gone into the making of this trend now called by the new name mental hygiene of industry. Sociologists, psychologists, industrial managers, and physicians, out of their different experiences, have been led to consider the possibilities of more exact methods of using and developing mental power in production. A very striking patchwork paper could be made of quotations from the literature of industry referring to the primary importance of understanding mental factors. "The price of maximum production is maximum

* A report of work done in collaboration with the late Dr. E. E. Southard, Director, Massachusetts State Psychiatric Institute, Boston. Read before the Mental Hygiene Division of the National Conference of Social Work, New Orleans, April 17, 1920.

personality for every human producer'' is the conclusion of one experienced director of personnel. The Chief of the Division of Labor Administration, Working Conditions Service of the Department of Labor, a year ago said that ''the problem of managing human beings in industry means handling the human element that goes into production with the same understanding of the feelings, instincts, prejudices, and characteristics of the workers as the management has of the materials and mechanical forces which it uses.'' No better evidence that the movement is under way could be cited than the fact that investigations on the subject are being conducted by the Engineering Foundation, of New York, and the joint research organization of the American societies of civil, mining, mechanical, and electrical engineers.

Knowledge concerning mental hygiene has been gained largely through the study of mental diseases. It is the psychiatrist, the specialist in mental diseases, who knows most about the causes and results of temperamental peculiarities and personality defects, of how to develop healthful habits of thought and to control unwholesome ways of thinking. As in other fields of knowledge, particularly education and physiology, the study of the abnormal has thrown the greatest amount of light upon normal or average conditions. Human nature is most readily studied in the beginning through its most conspicuous examples. What happens in the minds of mentally diseased persons is what happens in some degree, in one way or another, in the minds of all of us, just as the bodily changes of sickness are repeated in some measure or form in well persons.

The mental hygiene of industry is concerned not only with the prevention of mental disease, but with the mental health and vigor of all employees. The number of workers with actual mental disease will be small, probably only a few cases in a year in a plant employing several thousand. To be sure, the harm that may be done in any organization by these cases is out of proportion to the size of the group; but the time required to deal with this group intelligently, if they are properly understood through medical advice, is relatively very little. The next group for the mental hygienist to con-

sider are the individuals who are ordinarily called "difficult," "peculiar," "cranky," "touchy," "irritable," "moody," "ugly," "disagreeable."

About 50 per cent of the clients of social agencies, according to our estimates, are in one or the other of these two groups—that is, have either a mental disease or some mental or nervous peculiarity that must be reckoned with. Among our own acquaintances, we should probably find that 50 per cent have personal peculiarities that must be taken into consideration in dealing with them. The other 50 per cent will go on their way without showing any very evident effects of the treatment they receive. They will make good in spite of all obstacles. But this third group of energetic, healthy-minded persons have also need of mental hygiene in preserving and increasing their mental vigor. We are all of us continually trying, consciously or unconsciously, to develop our mental powers, to find for ourselves principles of mental hygiene. In industry, mental hygiene would apply to (1) a small, but potentially important group of mentally diseased employees; (2) a large group of individuals, possibly nearly half of the working force, whose mental character is such as to require special consideration; (3) the largest group of workers, possibly a little over half, who have no appreciable mental difficulties and whose problem is chiefly to develop their mental ability.

The practical situation divides into three propositions which present themselves in the form of questions: (1) Does industrial organization call for attention to individual mental characteristics? (2) Can the mental sciences give practical help in dealing with minds in everyday action? (3) Is it feasible to use mental science in industrial organization? There would be few found to-day who would answer the first question in the negative. The second has been answered affirmatively in innumerable instances and places, and the answer can readily be found by any one who will take time to gather the evidence. Psychiatry and psychology have already advanced far enough to make contributions to mental hygiene and are of great practical value. Propositions one and two may be said to be proved. The time has come to work upon

proposition number three. Face to face with the practical application of mental hygiene in the complex field of industry, a bewildering and tremendous prospect confronts us—a new world to be settled. A great many experiments under different conditions will be required before authoritative statements can be made. The industrialist who looks for proof that he can improve his organization through mental hygiene, before attempting it will have to wait a good many years; but the indications are strong that the industry that is fortunate enough to secure the personnel for trying the experiment forthwith will gain immediate benefits.

The inquiry into this subject undertaken by Dr. Southard for the Engineering Foundation was the outcome of some work begun at the Psychopathic Hospital in Boston in 1914. When I went there to develop the social service in 1913, I found at once that many of our patients who were started on an industrial decline were competent and even excellent workmen, and that with a little assistance in adapting themselves to their employment and an explanation of their condition to their employers, they could be refitted into industry. This led to the idea that similar methods of understanding and assistance might keep other employees from falling into the condition of hospital patients, and further to the thought that mental hygiene, necessary for the psychopathic employee, would also be beneficial to all persons in employment, to the end of promoting their efficiency and personal satisfaction. A committee was formed to carry on a special investigation of the subject, on which psychiatry was represented by Dr. Herman Adler and industry by Mr. Robert Valentine. A special social worker for psychopathic employees was engaged, and men patients between the ages of twenty-five and fifty-five were selected for the study. This case work has been carried on, with temporary interruptions, up to the present time, and 105 patients have been assisted and studied; 74 were adjusted industrially. Of the rest, 1 patient died, 7 were committed to hospitals, and 1 was temporarily sick in hospital; which leaves 22 in the community who failed to become self-sustaining. Of the 74 men who made a successful adjustment, 6 did rather poorly, but managed to get along, 21 did only fairly well, and 47 did very well in employment.

In addition to the cases assisted, industrial histories over a period of five years have been secured for 250 cases. A report of these cases will be published later. The continuance of the work was made possible by contributions from the Committee of the Permanent Charity Fund, Incorporated, Boston Safe Deposit and Trust Company, Trustee, which still continues to contribute to the present inquiry, conducted this year under the Engineering Foundation.

In June, 1919, Dr. Southard undertook for the foundation an investigation of possibilities in industrial psychiatry, to which he gave the more inclusive name mental hygiene of industry, covering the contributions of psychiatry, psychology, and psychiatric social work. He had expected that the inquiry would take shape in a handbook presenting the subject from various points of view. Before his death in February of this year, he had written three papers, addressed in turn to the employment manager, the psychiatrist, and the mental hygienist. Three other papers were in preparation.

In beginning the inquiry, it seemed desirable to review the literature of industrial personnel work and to learn by personal interviews the attitude of workers in that field. A bibliography of 1,600 titles dealing with the human element in industry has been collected and may be published.

Twenty-five centers of industrial work in thirteen cities were visited and about fifty persons interviewed—personnel workers, industrial physicians, and managers. We had expected that the next step would be to survey certain plants, to demonstrate the extent to which psychopathic conditions affect employment, led by our Psychopathic Hospital studies to believe that it could be considerable. We found such a lively appreciation of this among the experienced industrialists interviewed that a survey for the purpose of collecting information on this point appeared to be unnecessary and, instead, surveys seemed to be needed for the purpose of making practical applications of our present knowledge in given plants. For this purpose Dr. Southard developed the idea of a mental-hygiene working party. "Such a working party would be of value in almost all other fields of mental hygiene —for example, in the survey of a state or district, an occupation group, a racial group, or any other special group of per-

sons whose mental hygiene demands attention. Parenthetically, I am sure you will all agree that there is hardly any group of persons in the world that would not benefit from mental-hygienic analyses made upon the triple lines herein indicated. Thus a working party, composed of psychiatrist, psychologist, and social worker, can already be found in advanced juvenile courts, and even in certain courts for adult cases, and would undoubtedly be of the utmost service in all domestic-relations courts. Again, in schools and in various institutions for the care of children, this combined insight would penetrate many a dark corner. But industry seems to me to be the nearest problem to-day to the hand of mental hygiene. One is impressed with the readiness of industry for such working parties in mental hygiene."

There was no lack of evidence on my visits to industrial plants that psychopathic employees were a recognized problem. Usually the cases cited were among the best workmen, and the problem was how to keep them at work. It will be of interest to list some of the instances that were told to me, and also some of the opinions expressed. The following cases are selected for mention:

1. Man who thought he could not do his job and was found to be worrying about the headaches of his wife, also an employee. When given assurance that his wife would be transferred to a position more favorable to her health, he made good.

2. Girl who would get "fussed" over her work and finally have a hysterical fit; the doctor found she had a sex obsession. She was a good worker. She is now considered one of the best workers and one of the nicest girls in the plant.

3. Girl who could concentrate only until an early hour of the afternoon. Every few weeks she would get wild and leave her work, saying that she could not stand it another moment. Her problem was solved by putting her on two different jobs and changing her work every day at noon.

4. Man who feels "bum" all the time and is one of the best workers.

5. Foreman who asked to have his wife visited. His wife, he said, was "nervous." It was found that the man himself was nervous, that his wife thought he had changed very much in the last few years. She said that he cried in his sleep and that he complained of the conditions of his work, although he was absorbingly interested in it. He is a strong, healthy-looking man. He was very suspicious of direction and would not accept an assistant foreman. The failure to break in an assistant would mean loss to the company if this man should become incapacitated.

6. Girl with hysteria, cause of which was found to be the serious illness of an intimate girl friend.

7. Case of traumatic neurosis in which permanent paralysis resulted after a useless operation upon the hand.

8. Man with back curved after a slight accident from which no physical injury remains.

9. Man who occasionally stops work to sing and preach, suddenly stops, and with a laugh goes back to work.

10. Young man several years in army service who was mute after a shell explosion for a month; now shows hesitation in speech and is slow in manner. Although he has made good at machine work, he feels shaky. He thinks he feels worse and wants to be transferred to office work.

11. Man who had "shell shock" in the army who seems peculiar and does not do satisfactory work.

12. Superintendent who has no use for women. Carries this to such an extent that women employees cannot consult him.

13. Stenographer who is a fairly competent worker, but seems dull and makes mistake. Employment manager feels that there is something wrong with her.

14. Man laid off in slack season after fifteen years of employment; has such an unfavorable reputation that it will be hard for him to find another job. Talks continually, is suspicious, thinks everybody is against him, and has given some reason to question his honesty.

15. Over-busy girl who is a fine worker. When allowance for her peculiarities was made, she proved to be very useful.

16. Man who prided himself upon expert knowledge by which he could revolutionize the industry. He wrote various letters denouncing all who opposed him. Once he was the leader of a small group of workmen.

17. Very capable "normal" girl who made unusual mistakes in her typewriting for several days and then had an attack of hysteria. After a few days at home she seemed all right.

18. Foreman, a highstrung man, in whose department all the employees seem tense and irritable.

19. Man who ran up and down the shop with a bucket of molten metal. He was committed to a hospital for mental diseases.

20. Morose, surly Italian discharged for drawing a razor upon a fellow employee. This man had a record of having been employed by the same firm seven times within three years. The reasons for leaving were as follows: refused to do work; did not show up; not satisfied; dissatisfied; left without notice; dissatisfied with earnings; discharged. He seems to have done about the same grade of work throughout and not to have shown mental deterioration.

21. Colored laborer who would dress up once or twice a month on Saturday in white trousers, frock coat, and silk hat and walk up and down the main street of the works. On that day he would not report for work, but otherwise was a satisfactory employee.

22. Good worker, employed for twenty years, has a belief that there is an electrical current in his body pulling him from side to side. Once in a while he comes to the superintendent to talk about his condition. Apart from this delusion, he is "quite normal." He gets along well with his mates and has not fallen off in his work.

23. Foreman who went to pieces six months after being promoted from the bench. He became excitable and was irritable when spoken to by his men and would sit and cry in the superintendent's office. After two weeks of such behavior he was sent away for several weeks and seemed all right on his return. When put back at his former work, he was quite competent.

The following are some of the opinions expressed in regard to the importance of mental factors in industrial organizations:

1. A director of personnel in a large firm says he believes that there are great possibilities in the application of psychiatry to industry. He thinks that the only way to have this point of view generally accepted is by demonstration. He desires to secure a psychiatrist to take charge of the medical department in his factory.

2. A physician in charge of a large industrial medical clinic says that they have a great many nervous and mental cases. He plans to engage a psychiatrist on part time.

3. The secretary of an employment managers' association says he believes that industry must take into account variations of temperament to attain successful management. He sees steady progress along the line of individual study of employees.

4. An employment manager, who interviews all employees who are leaving, thinks mental factors play a large part in turnover.

5. An employment manager thinks that mental causes are probably at the bottom of 90 per cent of the turnover and 50 per cent of absenteeism. The manager of the firm believes that psychiatry has a contribution to make to management.

6. An industrial physician states that he has no doubt that there is a valuable investigation to be made in industrial mental hygiene. An assistant physician in the same department says that a great many employees come repeatedly to the dispensary whose troubles are evidently nervous, but cannot be exactly diagnosed because there is no psychiatrist on their medical staff.

7. A physician in the medical department of this firm says that he believes that a number of men who come voluntarily to the dispensary and then refuse treatment are mental cases. He found a large number of nervous and mental cases, more than in other plants that he is acquainted with, and thinks that is due to the fact that he worked for a time with a psychiatrist and is more apt to recognize mental disorder than the average industrial physician.

8. A physician in charge of the medical department of one of the largest factories in the West said that his department had many cases of mental deficiency and mental disease and that he was thinking of having a psychiatrist on his staff. He said that there were many epileptics in the plant, some of whom he had seen carried into the dispensary in convulsions as many as a hundred times. It was the policy of the firm to employ them on work away from machinery. He thought there was a great deal of mental-hygiene work already being done in industry more or less unconsciously.

9. A member of the firm of a large manufacturing company said he believed that there were a large number of nervous and mental cases among his employees. The employment manager of this firm attributed 75 per cent to 90 per cent of the turnover to mental causes—that is, to the workmen's attitude. He was engaged upon a study of absenteeism from the point of view of mental causes.

10. A woman employment manager, having heard recently a talk given by a psychiatrist to employment managers, which she had immediately found practically helpful, was eager for more psychiatric information.

11. An industrial physician had been considering making provision for an estimate of the mental condition on the examination blank used in engaging employees. This physician would like a psychiatrist on his staff.

12. An employment manager said he would like to have mental-hygiene talks for his foremen, realizing that almost every one has some wrong mental processes that stand in the way of his being positively constructive.

13. The director of the industrial-relations department in an extensive industry said that employers now realize that temperament is a factor in industry, and are aware of the importance of allowing for different temperaments, but they do not yet recognize that these temperamental differences can be evaluated and dealt with successfully by medical experts. It will be necessary to demonstrate that temperamental peculiarities are due to fairly well understood mental processes.

14. A trade unionist thought that the labor leaders are beginning to realize the possibilities of a combination between science and industry. He thought that an experiment in the application of psychiatry to industry would do more than anything else to convince the labor unions that the trend in industry is already toward individualization of the employee, and that if psychiatry can contribute to that it will be doing an important service.

15. The head of an industrial-service department in a large plant had listed as part of his program for the coming year the education of department heads in mental hygiene. He said he hoped to teach them to recognize and deal intelligently with mental deficiency and with mental disorder.

Of one hundred Psychopathic Hospital cases presented in a book on psychiatric social work which Dr. Southard had almost completed, and which I shall be able to publish shortly,

forty-two cases have marked industrial interest, although the cases of this series were selected without particular reference to industry. A significant thing in these cases is the prominence of family problems affecting the worker's industrial capacity. A family adjustment may be the root of the employment difficulty. In twenty-three of the forty-two industrial cases there was a family difficulty—financial in eighteen cases, a matter of illness in wife or children in nine cases, and a situation of marital discord in nine cases. A few instances briefly described will serve as illustrations of the problem of the psychopathic employee as seen from the hospital out-patient department:

Case 1. Steam fitter, competent skilled workman. Fairly regular in employment. Essentially a family problem of non-support and marital discord. Wife sick. Daughter sexually delinquent. Children sick—(1) chorea, (2) tuberculosis, (3) infant feeding case.

Case 2. Cigar maker with fear of open spaces. Recovered and works regularly as insurance agent. Wife steered through illness.

Case 3. Laborer with psychoneurosis dating from an accident. Feebleminded. Wife not well. Son feebleminded. Family income insufficient. Work found; has been capable and steady.

Case 4. Salesman discharged after an attack of manic-depressive psychosis. Since recovery has been steady and dependable, working regularly, but able to secure only temporary positions. Wife died, leaving nine children under sixteen.

Case 5. Draftsman who imagines an unfavorable attitude on the part of his fellow employees. Became unable to work. Got a chance to work by himself; is doing well.

Case 6. Elevator operator discharged for pilfering, suffering from a depression. Wife, an epileptic, had left him, taking their child. Family reunited. Now one of the best employees of another store.

Brief abstracts of the three papers written by Dr. Southard as a result of our investigations may be offered as the best means of presenting his conclusions. *The Movement for a Mental Hygiene of Industry* is a paper addressed to employment managers. It proposes the term mental hygiene of industry as a new term for familiar modern tendencies, and points out that our ideas about it have been cleared up by the war achievements of psychologists, psychiatrists, and social workers. "If there is a military psychiatry entirely aside from the problems of the front—i. e., a military psychiatry

due to the existence or development of more or less mild and incapacitating nervous and mental diseases in American camps already on this side of the Atlantic—it is plain that an industrial psychiatry of similarly large dimensions must exist. Perhaps of larger dimensions! Women are engaged in industry. Older men and women are found in industry than the men of military ages. Industrial risks exist, perhaps not so acute as the war risks, but of a very varied nature."

The personnel of mental hygiene as applied to industry is described as the industrial psychologist, the industrial psychiatrist, and the psychiatric social worker. "The keynote of this systematic attack on industrial personnel problems by means of mental-hygienic data and methods is the pooling and coöperative combination of expert engineering interests and expert medical and psychological and sociological interests; in brief, the invoking by the expert in industrial personnel of the aid of all available experts in personality, to the study of which the whole personnel problem must reduce.

"The interested personnel man or lay reader is implored not to take sides for one or another claim or counterclaim by medical men, psychologists, and others concerning the virtues of special methods. The topic is growing a little controversial; but on the whole the quarrels about method are superficial and the unanimity of experts extraordinary. No doubt the trials of the war served to mature and season the experts on all sides.

"Another warning! Every time the world has tried to measure things more accurately, many foolish persons have risen to protest. Not a few medical men and psychologists will rise to say over the same formula against the mental hygiene of industry. It is to be hoped that, at this late date of the world's history, we can jump this zone of senseless protest against what must inevitably succeed—namely, a program of more expert study of anything whatever, including the human personality, wherever at work.

"The movement for a mental hygiene of industry is neither an outgrowth of the efficiency movement—Taylorism and the like—nor an outgrowth of the workmen's welfare movement —economic interest in shorter hours, better working condi-

tions, and the like—though mental hygiene does effectively combine 'efficiency' and 'welfare.'

"On the contrary, a stream of independent developments in our knowledge of personality (medical, psychological; illustrated, for example, by the kind of insight into human nature displayed by William James) is now pouring itself into a branch of engineering—personnel management—which has been running parallel for some time.

"Perhaps the argument for a mental hygiene of industry may be put into a nutshell form as a question: Why should not industrial managers seek the aid of (a) those who can measure at least a few of our mental capacities and have shown their abilities in war work, of (b) those who are the best specialists we yet have in temperament and the best experts in grievances yet developed, and of (c) others less professionally trained who are capable of tracing out or helping to trace out the actual situation of, per example, labor 'turnover' as shown in the individual instance?"

The Modern Specialist in Unrest: A Place for the Psychiatrist in Industry, was given as an address at the fortieth anniversary of the Boston Society of Psychiatry and Neurology. It aims to "awaken the interest of psychiatrist themselves to what must be conceived as another immediate addition to the community functions of the psychiatrists." The psychiatrist has always been a specialist in unrest. "Unrest on the part of the individual is the big problem of the psychiatrist; year in and year out he comes in contact with the finest, as it were, and the most brilliant examples of unrest—namely, certain patients in his wards. If this general account of things be correct, the psychiatrist ought to have a message for industry. Psychiatric knowledge about the unrest of the individual ought to be turned to account in our analyses of group unrest. The theory that group experience leads to group thought, which in turn leads to group action, may be sound theory for a portion of industrial phenomena, but individual experience, individual thought, and even individual action are also factors in industrial situations. How far is unrest a matter of group, or crowd, or mass psychology? How far does mass psychology depend upon the psychology of the individual member? That

portion of the unrest problem which depends not upon group experience, but upon individual experience, not upon group thought, but upon individual thought, and finally not upon group action, but upon individual action, is the proper topic for the psychiatrist."

The idea of a mental-hygiene working party to make investigations in particular industries is developed. "A word or two about the respective functions of the members of a mental-hygiene working party. For the benefit of those who come to this problem for the first time, let me insist that such a working party is not proposed for the purpose of supplanting the employment or personnel manager or any other major or minor executive in the industrial plant. I hope to convey by the term working party the idea of an investigation occasional rather than permanent, carried out by special officers having the weight of certain connections outside of the industrial plants themselves. Of course the psychological examiner will no doubt prove a relatively permanent portion of the organization of an industrial plant, as soon as the managers of these plants get clearly in mind the army successes of psychology in the classification of personnel and the elimination of the unfit through group and individual mental tests. I think that portion of the propaganda for mental hygiene may be regarded as properly under way. I am bound to say that I think the plant has been adopting it more as an efficiency device than as a welfare or social adaptive measure, at least in certain plants. But this tendency to exploit the values of mental measurement for the mere elimination of the individual from a particular plant will be short-lived if we can somehow kindle the spirit of mental hygiene in the whole industrial problem. After all, the psychological examiner will find himself of greatest value in the employment or hiring side of the plant's work. As the years pass, the psychologist may also learn to contribute to the problem of promotion upon lines of vocational psychology. But for the present the psychological examiner, in the narrow sense of this term, will be of decidedly lesser value in the interpretation of the discharge rate or turnover in industrial plants. The industrial plant should have the list of discharged employees gone over from time to time by a consultant psychiatrist or a neurologist

interested in the psychiatric side of this work. Such consultant psychiatrist should be in complete touch with the psychological examiner and should have at his disposal such records of mental testings or other recorded impressions as the psychologist may have. He should likewise be able to secure and interpret the records of social work, especially those made in connection with discharged employees. The psychiatric social worker, like the psychological examiner, will probably become a permanent element in the plant, although most of her work may well be done outside its walls in the community and especially in the families even of those who become industrially disabled and of those who are discharged for such reasons as are consistent with the spending of the plant's time and money on their families. Luckily, in advanced urban communities the standard of social welfare has been advanced at least to the point reached by the standards of efficiency inside the plants. The result is that by a minimum of exertion on the part of the social worker, proper transfers of these families of discharged workmen to other agencies can be arranged for. Where there are a number of industrial plants in a single community, the social workers connected with these plants would naturally be closely associated with one another in their social conferences and society meetings. Industrialists tell us that coöperation is more the order of the industrial day than competition. However this may be in industry as a whole, there can be no doubt that the social treatment of families of employees discharged from plant A will benefit the turnover sheet of plant B and C, etc. If plants B and D employ social workers of like skill, plant A in turn will benefit in its turnover sheet. In brief, the welfare of the discharged means the efficiency of the plant. The general problem of turnover is aided by the well-known principle of mutual 'back scratching.' Meantime, the welfare values obtained for the community as a whole run beyond the superficial relief of the industrial skin."

Trade Unionism and Temperament: Notes Upon the Psychiatric Point of View in Industry, was delivered at the 1920 conference of the National Committee for Mental Hygiene and is a "plea for the inclusion in the programs of industrial medicine of the neglected field of mental hygiene"

and a prediction that "industry will shortly demand from the psychiatric branch of the medical profession various consultants who will not do their duty either by medicine or by psychiatry if they do not look attentively into these new matters."

The discussion of temperament in trade unionism followed Professor Hoxie's work *Trade Unionism in the United States,* published in 1917. Hoxie's four functional types found in trade unionism—business, uplift, revolutionary, predatory —are described as corresponding with the four classical temperaments familiar to psychiatrists—phlegmatic, sanguine, melancholic, choleric. The argument is that the analytical point of view of modern psychiatry in the study of temperament may be of value even in such complex labor problems as trade unionism. "In short the individual categories of medicine—the art which of all arts has from the beginning taken the individual as its object—will, we hope, be of some service to the world in such complicated fields as trade unionism. Mass psychology and mass psychiatry may be a thing of the future of undreamed-of proportions and quality. We have only the minds, normal and abnormal, of the individual men to go upon. Can we discern in the nebulous and mobile outlines of trade unionism, once more recurrent, the classical trends of temperament? If we can be sure of our analysis here, we can no doubt meet the problems of trade unionism with much more understanding and with very much more sympathy. The mental hygienists, I venture to say, as represented both by psychiatrists and psychologists, will have in the long run a considerable contribution to sociology."

Other ideas that Dr. Southard intended to develop in later papers are "specifications for clinics to demonstrate to employment managers certain useful points in character and temperament"; "analysis of 250 industrial histories of psychopathic employees," the data for which have been collected; and "comparison of tendencies to violence in the insane with like tendencies shown in industry."

In the future results should be sought through practical measures to supply in particular plants what psychiatry has to contribute to personnel problems. Such practical measures

are the mental-hygiene working party to survey a plant, the consulting psychiatrist, and the psychiatric social worker connected with the personal service. Many studies could be made within the plants for the purpose of indicating the value of such measures, but the emphasis should be upon an actual trial on a large scale of methods already proved to be of value in individual cases. Application of what is already known will not only yield immediate practical results, but will also be the shortest road to further knowledge.

The difficulties of practical application may loom large. One manufacturer who was kind enough to list for us the objections that might be raised by industrialists was able to set down seventeen typewritten pages of possible objections. They can all be met by trial, but probably not by argument. The objection in the foreground is that large industrial firms employing thousands cannot give attention to the individual employee. This is a problem of organization, which is tersely put by Dr. Otto P. Geier when he says, "While it is advisable to think in terms of the mass, it is even more important to act in terms of the individual."[1] Another industrial manager, facing the difficulty squarely, says, "The mistaken idea that a workshop becomes so large that it is impossible to deal with the individual is doing tremendous damage to-day. Does a firm ever get so large that it cannot deal individually with its customers? If it is possible to deal and make individual adjustments with customers, why should it not be less difficult to deal with the employee individually? Just as the circumstances surrounding the purchase of the customer must be different, so are the capabilities, class of work, personalities, etc., of the individual worker incapable of satisfactory mass adjustment."

The terminology of medical science is a minor cause of prejudice in the industrial field. But workers who have familiarized themselves with the almost unbelievable names attached to some of the machines and materials used in manufacturing industries will not hesitate long before accepting such easily acquired terms as "psychiatry," "paranoia,"

[1] Geier, Otto P. Employment Management and Industrial Medicine. *Modern Medicine,* Vol. I (new series) pp. 213–15, July, 1919.

"cyclothymia." Even "hypophrenia" and "pseudologia" may come in time to replace the harsher terms "stupidity" and "lying"!

The fear that the recognition of mental disorder will discredit the worker may act as a deterrent to the movement. Big mental diseases cannot be concealed, but it is customary to ignore the little bits of mental disorders that stand to mental disease about as a cold in the head stands to pneumonia. Yet these little mental troubles often impair efficiency and happiness more in the long run than a severe attack of some disorder. Most of us would rather have an attack of pneumonia than a chronic cold in the head. It is thought that the individual worker will be alarmed at the idea of attributing his difficulties to diseases or to innate weakness. It has not been found difficult in individual cases dealt with in hospitals to reconcile employees to the idea that their difficulties have recognized causes; in fact, as a rule they welcome the idea, as it is a relief to them to know that there are means of help. In one plant visited, the head of the medical department thought of beginning a mental-hygiene program with the executive force, where turnover was lower and intelligence higher. The best argument with the worker of the value of mental-hygiene methods will be the increased satisfaction of individual employees who take advantage of them. In relation to one mental disorder, feeblemindedness, it has been proved and generally accepted that the worker profits by recognition of his mental condition. Individual consideration for the feebleminded has led to a better realization of their productive capacity and has tended to increase their productivity as a class.

Gradually all points of view from which industry is studied —economics, medicine, engineering, labor, capital—are coming to a focus upon the basic fact that production rests upon mind. Mental power is the greatest force in the world, and it is still to be studied from the standpoint of industrial production. The beginning made by the Engineering Foundation is full of promise. In a recent article in the *Engineering News Record*,[1] Miss Frances Keller says, "The application of man power to production in its essence is the province of

[1] See bibliography at end of article.

science to solve—just as much as the application of heat power and electric power to production was the province of science to solve." And again, "Nothing but science has ever been able to understand power of any kind. Engineering is the only method that holds out any promise of ultimate success. Increasingly the engineer untrained in man power, but having the essential groundwork, is becoming the manager of men."

There can be no doubt that as the field of study and practice in the mental hygiene of industry develops, the social worker—whether so called or otherwise named is a matter of no consequence—will be required. There is likely to be a demand for a large number of psychiatric social workers trained in the general technique of social investigation and treatment and the special technique of personality study. The same training that has been found indispensable to the adjustment of individuals here and there who have come to the attention of social agency or hospital will be required for any extensive program of personality adjustments within an industry. The social worker's knowledge of family and community relations and special skill in securing personal histories and in handling people should form the best possible foundation for personnel work. With additional instruction and training in matters pertaining to industrial organization, the social worker is likely to prove an asset to industry.

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THE STATE HOSPITAL IN RELATION TO PUBLIC HEALTH*

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OVERWEARIED as we may be from the hot enthusiasms and the sharp idealisms of the war period, and deep as we may be in the depressive spiritual reaction from those days, yet we are aware that a new spirit has come into the world. This spirit may be difficult of definition, but we are made conscious of it in many ways and by activities in various fields of human endeavor. It has something in it of aggressiveness, of the consciousness of power that is born of success, of fearlessness in facing problems, of a keener sensitiveness to injustices and unfairnesses, whether in the political, the economic, or the social field, a greater awareness and intolerance of needless evils. And to the elements of this spirit may be added what to psychiatrists must give satisfaction—a desire to investigate, to know facts, to be guided by facts, and to meet issues squarely.

A few years ago our good friend and one-time chief, Dr. E. E. Southard, from whom we gained much inspiration, read a paper in which he discussed what he called the Kingdom of Evils. Dr. Southard's contention was that the evils in the world are not numberless, as appears on a casual survey; that the myriad forms of evil that confuse and discourage us are but symptoms and signs; that when these are grouped and classified, a number, not discouragingly large, of major evils will be found; that it were better for the right-minded to save their energies in attacking numberless symptoms of evil in numberless ways and places and to turn the energies thus fruitlessly expended into carefully classifying the major groups; that once the major groups are identified, it will be the first business of all to make a concerted attack upon them. Toward this end Dr. Southard himself attempted a classifica-

* Read at the Midsummer Meeting of the Joint Board of Trustees of the Michigan State Hospitals at Kalamazoo, Michigan, July 15, 1920.

tion of the Kingdom of Evils. In this classification he was not concerned, of course, with the old chameleonlike moralities, but with the larger aspects of evil.

In Dr. Southard's classification of evils one is not surprised to find sickness. Obviously it belongs there. But the world has not long realized that it belongs there. Sickness has not been an evil in the minds of people. From being a punishment and a scourge it had come to be a thing to be expected and to be endured as the necessary part of the end of man. But while the human machine must in time wear out, it need not be consumed by conflagration. Sickness is an evil, and men are fast coming to realize it and to organize their forces on that basis.

Many lines of thought from various fields of human effort have contributed to the development of this point of view, and some have been from fields far apart from medicine. Medicine, however, as it has become more socially conscious, has been gradually working in this direction. The treatment of disease is a negative social contribution—important, to be sure, but negative and humanitarian. Thus to link the humanitarian with the negative is not to underestimate his contribution, but it is to assay him critically, the better to estimate or revalue his worth, a proper psychiatric function. No one knows better than the psychiatrist the significance of humanitarianism. Humanitarianism surely is not the *opus magnum* of human evolution, with its leached instincts and sublimations—good in the sense that it is better than bad, but bad in the sense that it represents the defeat of better.

Socially conscious medical men could not long tolerate such a negative position, once an opportunity for greater positive contribution were presented. This opportunity came with preventive medicine, and into the field of preventive medicine entered men of vision whose instincts needed not so much sublimation as wider outlet. The prevention of disease represents a greater positive social contribution; but it is not free of negativism and it was not to be expected that medicine, with its great potential for positive good, would rest here. Medicine is preparing for another move forward. One observes in medical literature, discussion, programs, and health campaigns a new note—not alone that the ill shall be made

well, that the well shall be prevented from becoming ill, but that the energies of medicine shall be given to extending the power and happiness of man through developing to their maximum his physical and mental abilities. The campaign in social hygiene is no longer for the prevention of venereal disease alone, but for an intelligent understanding of sex; the anti-tuberculosis campaign is not alone for more sanitaria for the tuberculous or a direct attack upon the incidence of tuberculosis, but for better health in general; school physicians, while still performing the important function of inspecting adenoids and tonsils, are giving their larger energies toward developing among children proper habits of health and hygiene; the attack upon infectious disease is continued with even greater zeal, but attacks are also led against diseases of deterioration through campaigns for better health and more hygienic living in general. These endeavors represent positive social contributions as opposed to the purely negative contributions of the past. Medicine has therefore progressed from empiricism to scientific treatment, to prevention, and finally, if you will, to productive medicine.

Has psychiatry any such positive contribution to make? Is psychiatry prepared to make such possible contribution? One cannot doubt the ultimate answer to these questions, but the immediate answer will depend upon how far psychiatry has advanced in the preliminary steps of this evolution from empiricism through the negative aspects of medicine—treatment and prevention.

As you are not unaware, the first hospitals for mental disease opened in this country were as free of access as any other hospital. A patient with a sick mind could come as freely to such hospitals as his brother with a broken hip could enter a hospital of another kind. For some fifteen or twenty years this freedom continued. Gradually, for one reason or another, fairly or unfairly, doubt and misunderstanding arose in the minds of the public; the hopes with which these hospitals were built were disappointed, and from being the "state's greatest charity" the hospitals frequently became, with warrant or without warrant, the state's greatest source of scandal. In bitterness, disappointment, and distrust, legislatures built a legal stockade about the hospitals until prisons

were more accessible than hospitals; in fact procedure was much the same in both cases, with leniency in favor of the jail. Hospitals became isolated, socially and medically. For almost forty years hospitals have been endeavoring to free themselves from this tremendous handicap and have now largely succeeded. Laws permitting voluntary admission, temporary care, and observation have been passed in many states, and again the psychiatric skill of the community is becoming accessible to those who need it.

Originally the institutions for the insane were called asylums, a beautiful name with a beautiful meaning—a place of refuge. But unhappy connotations came to be built up around the term asylum, and legislatures have seen fit to change the name to hospital. But asylums cannot be changed into hospitals through legislative enactment. A building, a physician, a nurse, and a patient do not make a hospital. Even less do a thousand patients, three physicians, and a few poorly trained attendants make a hospital. Are our hospitals in name hospitals in fact? As one surveys the situation generally throughout the country, one is convinced that there are many excellent hospitals, that there are still too many which have only good housekeeping and a low per capita to recommend them—asylums in the proper sense—and that there are some that are but inferior jails. Putting it in another way, one may say that most state hospitals are rendering a humanitarian service, some are rendering a medical and scientific service, while still too few are rendering a positive social service in spite of the fact that they contain possibly the greatest potential for social service of any organized medical group.

The right of any state to call its institutions hospitals can properly be questioned, and least of all can a superintendent or a board of trustees take pride in an institution as a hospital, unless such institution has met the requirements that experience has shown to be needed in such institutions. These requirements are familiar to you, but they may be briefly enumerated:

A reception service.

Facility for proper classification and segregation of patients.

Facilities for active treatment, such as hydrotherapy and occupational therapy, and these in the hands of competent persons.

Properly equipped and staffed laboratories.

An adequate medical and nursing staff with a training school for nurses.

Frequent and regular staff meetings.

A system of adequate case records.

A parole system.

Social service.

The number of hospitals in this country that maintain such a standard is not inconsiderable and the number becomes larger each year. Asylums are not made into hospitals easily. When made, the transition has come through years of hard work and against many obstacles by earnest superintendents who have given to it the best years of their lives. There are hospitals in this country that stand as monuments to men who won them, not in a moment of exalted heroism as is so frequently the case with our better known awards of merit, but by courage sustained through long periods, through sweat and toil and sacrifice, and without the stimulus that comes from crowd action.

But no organization can live by maintaining past or even present excellencies. What was excellent yesterday is mediocre to-day and retrogressive to-morrow. Hospitals for mental disease have sat by the side of the road and performed their humanitarian service, binding up the wounds, as it were, of the generations that have crowded past them. In no generation have they been a vital, dynamic part of the community life. And yet they contain within their walls a potential force of unlimited value.

Once psychiatrists left their places by the road, took off their robes of negative humanitarianism, and put on the armor of the crusader. It was at a time when the best that was in men was challenged. At first the change from robe to armor was not recognized, and those about smiled and dubbed these psychiatric officers "nut doctors," and "nut doctors" they would have remained to the end had their services been limited to the negative one of caring for the insane, valuable as such a service would have been. But these

men soon became a dynamic force in the life of the army. Their contribution was a positive one, and with it came the respect of their brother medical officers and line officers alike. The handling of the problem of the war neuroses is familiar to you and need not be elaborated in this connection except to point out that the problem of the war neuroses is the problem of the civil neuroses. Several contributions that have not received so much attention may be mentioned briefly.

When the United States entered the war, an official request was sent from Washington to the commandant of the United States Disciplinary Barracks at Fort Leavenworth requesting an estimate on the increased provision it would be necessary to make in order to take care of the prisoners to be expected from an army of 3,000,000 men. After a study of the figures of the Civil War, the Spanish-American War, and the operations on the Mexican Border, the commandant replied that it would be necessary to provide for 50,000 prisoners. As a matter of fact, the Disciplinary Barracks, including the two branches, received approximately 5,000 prisoners—in other words, 10 per cent of the estimated number, based on previous experiences. This can be explained on only three grounds: (1) the enforcement of prohibition in the army in general and especially in cantonments and their neighborhood; (2) the activities of the War Camp Community Service and other agencies in furnishing recreation for men in their leisure; (3) the elimination by the neuropsychiatric officers of the potential delinquents of the army—the mental defectives, the insane, the psychopaths. The effect of the work of the neuropsychiatric officers in eliminating these potential delinquents was clearly shown when a survey of the prisoners at the Fort Leavenworth Disciplinary Barracks disclosed that the distribution of intelligence among them was practically that of an ordinary division of troops. Adler, in his report of the survey, points out that "there was an absence of the high proportion of defectives and psychopaths found in nearly all of our civil prisons. Instead of the 30 or 40 per cent of feebleminded and psychopaths found in the latter institutions, between 10 and 12 per cent were found among the prison population at Fort Leavenworth."[1]

[1] *Disciplinary Problems of the Army.* By Herman M. Adler, M.D. MENTAL HYGIENE, Vol. III, pp. 594-602, October, 1919.

The influence of the psychiatric and psychological examinations made in the camps at home was felt in the Argonne and on the Marne and the Meuse. Salmon, in speaking of the results observed by him in the A. E. F., says: "In the army in 1915 there were just one hundred thousand men, and those one hundred thousand men, who were taken without very much attempt at selection, contributed during the year 56 suicides. The A. E. F. contributed, of its two million men in two years, 94 suicides. That is, had the suicide rate in the A. E. F. been the same as it was in the unselected regular army in 1915, there would have been 2,240 suicides. The insanity rate of the old army in 1915—a year spent entirely in peace—was 3 per thousand. That is, 3 men were discharged for 'mental alienation' for every thousand in the total enlisted strength. The insanity rate in the A. E. F., where men were subjected to unprecedented stress and where many of the causes of mental disease that existed in the regular army in 1915 were accentuated, was 1.6 per thousand. That is, there was 47 per cent less insanity in the American army in France, engaged in active warfare during almost the entire period, than there was in the regular army in 1915, engaged in peace duties throughout the United States.

"One man in eight of the army of 1915 left the army before the expiration of the year through a criminal procedure, either desertion or a sentence of court-martial involving dishonorable discharge from the army. Had that rate prevailed in the A. E. F., two hundred and fifty thousand of the two million men in khaki who went overseas would have returned as prisoners, facing dishonorable discharge from the army. As a matter of fact, the total number of men who were returned as general prisoners was 1,731. You must remember, too, that offenses which are very slight in time of peace and are dealt with by summary measures are in time of war dealt with by general courts-martial and long sentences."[1]

These days are over, but from them have come a multiplicity of complex problems. The world is milling. The issues are considerably clouded by the dust that arises from the process,

[1] Remarks by Dr. Thomas W. Salmon at dinner of the Military Training Camps Association, January 17, 1920.

and there are earnest people who are conscientiously analyzing the dust. Leaders in various fields, however—the economist, the sociologist, the jurist, the statesman—have pushed through the dust screen and are making earnest efforts to find fundamental causes of the disturbance. Some weak-hearted have returned in a state of panic. There was another similar time. When thousands of men began to pour out of the trenches blind, deaf, and paralyzed, and to stream back upon the hospitals, general medical men who could find no organic lesions were puzzled and at their wits' end what to do. But the psychiatrist was not puzzled and, free of any feeling of panic, proceeded in a matter-of-fact way to readjust these individuals and to return them to the line of duty. The present situation is but slightly different. If there is any group that should be panic proof in the face of restlessness, discontent, suspicion, jealousy, cries of treachery, robbery, and murder, it is the psychiatrist, who at least has some insight into problems of human behavior.

In one respect, however, the situation is different. Many psychiatrists have removed their crusading armor and have returned to their humanitarian robes. The civil line officers —the state officials, the jurists, the educators—are left without special advice or counsel. At another time in another difficult situation one of the most useful officers was the division psychiatrist. The division psychiatrist was responsible for the mental health of the men in his division. He was a constant adviser of his superiors, both of the line and of the medical corps. It was his business to know his men, their weakness and their strength. It was he who supervised the examination of the men in his division in the elimination of the unfit. Through his assistants he was in constant touch with the morale of his organization. His constant inspection revealed weak spots as men began to break. With action imminent, he forestalled panic by plucking out those likely to precipitate panic. With his troops in action he was immediately behind them with his special hospitals organized to take care promptly of those who would find the task too difficult. Every officer and man had access to him and to his trained advice and counsel as personal crises approached. He was a dynamic force in his combat community. No one will

gainsay the usefulness of such an officer. But where is his counterpart in civil life?

Such force, such leadership is just as much needed to-day in every state and in every district in the country as it was two years ago on the battlefields of France. There is but one immediate source for such leadership and that is the state hospital. Most states are divided into definite hospital districts. A hospital receives its patients from a particular district. This is a definitely limited district usually not overlarge. The superintendent of the hospital may easily be familiar with every city, town, hamlet, and county in the district. All about him in this district are earnest people struggling with perplexing problems—industrial, educational, correctional, charitable. He is not apart from this community, but an integral portion of it. These problems are his problems and the problems of his staff, as much as they are any citizen's problems. He observes his fellow citizens struggling with what he all too frequently considers *their* professional problems, and as time goes on he receives into his refuge the by-product and sometimes the direct product of the prodigious labors of his friends. He calls it waste, damnable, needless waste, and yet the key to the solution of many of these problems remains locked in his own institution.

From 1915 to 1918, inclusive, the Michigan state hospitals received some 6,700 new patients, approximately 1,700 patients each twelve months. There will be a new 1,700 in the next twelve months. Where are these individuals and who are they? They are not a mysterious group that will descend upon the state like a plague from some far-off place and from some unexpected direction. They are our neighbors, our friends, and their children. They are not a group peculiar to New York or California or Texas, but citizens and children of Kalamazoo, of Grand Rapids, of Ann Arbor, of Pontiac, and of Traverse City. Their course is about run and they will soon be with us. But in the offing there is another 1,700 and as far as we can see yet another and another. It is a veritable army of living, breathing, unhappy individuals—1,700 within one year of us; 3,400 within two years; 5,100 within three years; 6,800 within four years; 8,500 within five years; 17,000 within ten years.

Some that we can see just over the horizon are mere toddlers who are to-day having their first brush with what is to them a surprisingly unfriendly environment and reacting to it badly and in a manner that is significant; nearer is the boy or girl *just* beginning to edge away from the crowd; the boy who has *just* found the false way around an obstacle; the lad who is beginning to doubt himself, but who is finding an explanation of his failure in the unfairness and unfriendliness of others; the boy or girl who to-day has *just* dropped his or her head in unhappy recognition of his or her inferiority, or the other fellow in the group who has *just* thrown up his head, frightened at the inadequacy he has found within himself, but who has buckled on an armor of self-defense, stands breathing defiance and ready to challenge authority. With increased puzzlement and confusion, misery and unhappiness, pitiful and tragic, these boys and girls will be moved along toward us year by year. Inefficiency, failure, and humiliation will be heaped upon them. As, without understanding and without guidance, they are pushed forward by the crowd about them, it will be but an accident whether some first reach us or the prisons. But in the years that are to intervene parents will labor with them, the schools will work with them, the judges of the juvenile court and the probation officers will do the best they can with some, and with some the higher courts, reformatories, and prisons will have to take a hand. Energy and money will be expended without avail upon them. But whatever the intervening steps, the end is failure. How difficult of readjustment they will be when once they reach the reformatory or finally find a refuge with us! And yet, pliable as they are to-day, how simple in many cases would the readjustment be now—how simple the psychiatrists who met yet more difficult problems of readjustment in the army know, and Campbell and Richards in Baltimore, Glueck and Brown in New York, Healy and Bronner in Boston, who in school or court have worked with these children, have pointed out. We are inclined to think of these individuals in the terms of end reactions as we see them on their admission to the hospital, and to be discouraged; it were better did we think of them in the terms of beginning reactions.

We have been speaking of the child we could just discern as

we looked ahead, but the older brothers and sisters of these children are at hand. They are in the schools to-day, they are in the courts to-day, they are entering industry to-day. And does any one presume to deny that these individuals, whether in school, court, or industry—unassisted, unrecognized for what they are, unassayed at their true value, misunderstood and misunderstanding—are the source of many of our most perplexing educational, judicial, industrial, and political problems? Problems of conduct lie in the province of psychiatry. And not alone of insane conduct.

Economic and social problems are to be solved only in a spirit of fairness and upon the basis of ascertained facts; but with the sifting of data in the ascertaining of facts, and in the determination of what is fair and just, there must be discussion, division, and even heated differences of opinion. It is not, however, from such fair differences of opinion, no matter how sharp, nor from such contentious discussion as may grow from it, that many of our difficulties and disturbances arise, but from the partisan agitation of individuals who, unhappy and disturbed by unsolved problems of their own personality, make an effort to maintain their self-respect against a feeling of failure, defeat, and inadequacy, either by rationalizing their difficulties in terms of the injustices of others, or by transferring the emotions born of their own sense of failure to elements in their environment. In the understanding of these individuals, whether partisans of one group or another, and the significance of their passionate outbursts, the social atmosphere may be kept clearer for a proper evaluation and judgment of the issues involved. In assisting these individuals in the solving of their own problems, not only may neuroses and possibly psychoses be prevented, but by proper reconstructive efforts the individual may be led to an adaptive plane, upon which he may find happiness and social usefulness.

We should not overestimate the amount of our knowledge or our ability in helping to solve some of these problems, but false modesty and an attitude of self-depreciation are equally wrong. This is not a time for sensitiveness. The need for trained men who are not afraid is greater to-day than in 1917. Building for peace is an infinitely greater task than preparing for war, and rebuilding after war has always tried men's

souls. But everywhere are strong men engaged in the process of construction. Professional group distinctions are not so marked. There is a new community of interest. In idle days we were jealous of our problems; interlopers must keep away. To-day we seek advice and counsel in contiguous fields—the jurist calls upon the educator, the industrialist calls upon them both, and all are asking questions of the psychiatrist. Psychiatry cannot shirk its part of the burden in such a program of construction. Contacts with these community problems may be made through a more extensive development of the out-patient departments of the state hospital, through a well-organized and active psychiatric social-service department, and by psychiatrists assuming advisory relationships with boards of education, boards of charity, courts, and labor and industrial organizations.

The state hospital in its district contains the potential for an inestimable service greatly needed. State hospitals all too frequently are pursuing a negative policy of humanitarianism, a part of, but apart from, the community. With the evolution of medicine from negative humanitarianism to positive constructive contribution, psychiatry and its hospitals will undoubtedly became vital, dynamic forces in their districts, pooling with others in a general community interest what they have of special knowledge.

IMBALANCE IN THE DEVELOPMENT OF THE PERSONALITY AS A CAUSE OF MENTAL ILL HEALTH

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FROM the standpoint of the psycho-biological growth of the individual, what may be called an imbalance in the development of his personality may be looked upon as one of the most important of the causative factors of mental ill health. On the other hand, the factor of balance in personality development is of paramount value in the field of mental hygiene. The value of this factor, important though it is in itself, is increased by the fact that to a large extent it is the result of wise training and a favorable environment. This makes of it a somewhat variable quantity which may be raised to its highest power if there is need to offset the results of handicaps of inheritance. Furthermore, it is an excellent foundation for a well-poised mind, and the cultivation of it is the surest way to prepare the individual for the stress and strain of life and the incidence of physical disease which in one way or another not infrequently prove disastrous to his mental equilibrium.

It is, then, because of the rôle that such personality development plays in the drama of our mental lives that the importance of avoiding imbalance in the character building of our children cannot be too greatly emphasized. Moreover, too great attention cannot be given to it, particularly in the first five years of life, since it is being recognized more and more that it is in the earliest years that the great tragedies occur that tend to warp seriously the individual expression of energy of later years.

The possibilities of balance and imbalance in the growth of the individual may be considered innumerable, and the study of them might be carried into the most minute of the characterological traits. The more important ones, however, which we shall discuss in this paper, may be considered as

comprising many of the important principles of mental hygiene which should be adhered to rigorously if there is to be accomplished in the field of mental medicine what has already been done in preventive medicine in general.

The first important instance of balance may be looked for in the physical make-up of the individual, which is probably the foundation of the personality. One phase of this balance is in the integrity of the various organs of the body; another is in their proper functioning and in the balance of their inter-relationship, in the accomplishment of which the internal secretions play such an important rôle. The habits of the infant, even from the first hour of his life, cannot be overestimated in the part they play in the foundation of such a sound physical basis, both from an organic and from a functional standpoint. A child with a highly sensitive nervous system who is allowed during the first two years of life to form only constructive habits of eating and sleeping has the most important foundation for a healthful existence, both mental and physical.

It is interesting to watch a child who is taken up each time he cries. The smile of perfect contentment and satisfaction that glows in his face when this means of quieting him is resorted to is sufficient evidence of the cause of his crying and of the satisfactory fulfillment of his desires. Such constant yielding to his wishes upsets the balance in his life. There is insufficient time for sleep; digestion is constantly interfered with; he does not develop as he should and, incredible as it may seem, we soon have what appears to be an infantile nervous wreck instead of a peaceful, happy vegetative creature adapting himself to and enjoying the routine of the world as he finds it without trying with Bolshevistic methods to upset the whole social scale for the whim of the moment.

A general practitioner was recently summoned to see a baby because he cried so incessantly that the family dreaded to have him baptized. Since no more complicated treatment seemed to be indicated, the physician gave him a good dose of castor oil, had him sleep in a room by himself, and told the family to let him alone. Before very long it was possible to have a peaceful baptism. Such an infantile method of

dominating the family may persist even in adult life, often expressing itself in tantrums that are indicative of the individual's poor adjustment to his environment. Strange as it may seem, children not only frequently decide what their own bedtime shall be, but also dictate the time for their parents to go to bed. Not long ago I saw a youth of fifteen who had always insisted upon his father's going to bed with him.

Again, in the matter of food, the child's preferences are not only frequently asked, but his prejudices are encouraged. A mother will leave each decision about food to the child, irrespective of dietary values, and even remark that it is difficult for her to remember her children's various preferences. It is generally conceded that a child does not know instinctively what diet is best for him and that idiosyncrasies in food should therefore not be encouraged. Campbell describes children who develop severe gastric symptoms in an attempt to dominate their environment.[1] Such symptoms may be considered unconstructive habit formations and are upsetting to the emotional as well as to the physical balance of the individual. The best safeguard against the elements of infection and exhaustion that may intervene at any time throughout life to upset the body's equilibrium lies in constantly maintaining the highest level of physical efficiency and mental balance.

The next significant balance in the development of the personality is the relationship between the physical and the mental growth of the individual. It is of the greatest importance that the mental development should correspond with the physical growth. This entails the development of inhibitions, mature attitudes, and altruistic or socialized impulses that should correspond with the changes incident to physical development. In his mental development, the child passes through various stages that are natural and desirable as stepping-stones of childhood. The importance of affording him every opportunity to reach the mental level that corresponds with his chronological age cannot be overestimated, for if the individual does not develop intellectually and emotionally, but remains at a childish level, he is unable to make

[1] Campbell, C. Macfie. *Nervous Children and Their Training.* MENTAL HYGIENE, Vol. III, pp. 16-23, January, 1919.

constructively the adult adaptations that will be expected of him. Certain immaturities, however, have great charm as elements of the personality, and may be considered undesirable only when they interfere with the personality's real lines of development.

The instability and antisocial conduct that are sometimes found during adolescence illustrate a temporary loss of balance between the physical and the mental. Cases are not infrequent, of course, in which the physical demands are always greater than the mental control; in which there is a permanent physico-mental imbalance. The following is an example of such an imbalance that was very marked during adolescence; it was grafted on an injudicious early training and, still more fundamentally, on what was probably an hereditary handicap.

Elizabeth, a girl who was studied at the Psychopathic Hospital at Bedford Hills,[1] had been brought up in a quiet New England town by her grandparents, who were devoted to her and offered to give her a good education. Her father had died when she was still a baby, and her mother brought up her other daughter and two sons in a suburb of New York. The hereditary factor referred to was suggested by the roving qualities of the father and of a brother, both of whom showed, besides, considerable nervous instability. Elizabeth remained with her grandparents and away from the rest of the family much of the time until she was fifteen and in high school. Returning to spend the summer with her mother in the New York suburb, she was greatly tempted by the town's gayety and its call to her adolescent longings. Instead of returning to her grandparents to finish high school and normal school, as she could have done, she remained with her mother, much against the advice of her entire family. She went to work, but changed from one factory to another, in quest always of less supervision and more gayety, even though the wages were lower, until two years later she was beyond the control of those interested in her and was associating with Chinamen in chop-suey houses.

[1] The Psychopathic Hospital of the Laboratory of Social Hygiene associated with the New York State Reformatory at Bedford Hills, New York.

In this case there was great physical activity and good mentality with, however, much general immaturity and poor judgment. In the stress of adolescence there was little latent power of control, and when supervision in her environment failed to be adequate, the balance between the physical and the intellectual, between emotion and judgment, was ineffectual, and she was carried away by the allurements of what she considered "real" life. Had there been more judicious training in her early life; had she been helped to develop better judgment in her early childhood; had she learned to face difficult situations instead of always being indulged as she freely admitted she was; had she been given constructive outlets for her energy, which she did not have in her association with her grandparents, then, we believe, when the years of adolescence arrived, made more difficult than usual because of inherited instability, the imbalance between the mental and the physical would not have been so hard to cope with, and she would have weathered the storms of adolescence with better success.

The next balance of importance in the personality is in the individual's expression of energy. Jung has emphasized the two important types of personality that demonstrate different kinds of energy expression.[1] On the one hand is the extravert type in which the energy is expressed freely, through obvious activity and loquaciousness. There is apparently little inhibition and the impulses flow outward and express themselves with ease in physical and mental activity. The introvert type, on the other hand, does not have the free outward expression of energy of the former type. There are inhibitions that prevent such active participation in an external world. A compensating form of activity takes the place of this in a more or less shut-in personality. There is much introspection. The individual lives within himself.

In order to maintain a balance in the personality, a combination of these two types must be cultivated: first, sufficient introspection and deliberation to develop a depth of personality, a resourcefulness, a reliance on self, and a wealth of feeling; and, second, sufficient outward expression of a spon-

[1] Jung, C. G. *The Theory of Psychoanalysis.* Washington: Nervous and Mental Disease Publishing Company, 1915.

taneous nature to enable the individual to give satisfying and constructive vent to his energy.

The following is an example of the kind of emotional experience that may upset this balance, inhibit spontaneous emotional expression, and produce a feeling of inferiority that results in undesirable repression.

A girl of five was playing statues quite innocently with her young boy cousins in the nursery. In order to make her look like the pictures in the big book downstairs, the cousins had removed her clothes, and she was posed on the window seat when her aunt, whom she greatly feared, entered the room. The aunt was thoroughly shocked at what she saw and called the child loudly by name. The mother was sent for, and, weeping, she dressed her daughter and took her home, without giving her a word of explanation. The child supposed that she had committed an unpardonable sin, something too terrible to be talked about, and grew up with the idea that she had disgraced her parents irrevocably. Her first name was so distressing to her on account of the association with her aunt's exclamation that when she was older, she had it changed. She always shunned the companionship of girls because she felt a sense of inferiority, of unworthiness, perhaps also of uncleanness, according to what she judged their standard to be. But boys, she felt, would understand and would not think the worse of her.

When she was eighteen, her father was very ill, at a time when her mother was several thousand miles away. The nursing was difficult, and it seemed to her that here might be an opportunity to expiate for the terrible sin that she had committed so many years before. She relieved the nurse each night, and during the night just before her mother's return she assumed a position that involved great physical strain, in order to give relief to her father. He lived a few hours after her mother arrived, and the girl then collapsed mentally and physically. She had, however, as a solace the idea that through her sacrifice she had atoned in part for her dreadful sin and felt assured that her father, at least, had understood and had forgiven her.

Years later she learned that the experience of her childhood was after all a perfectly natural one and should not have been

open to censure at such an early stage in her development. Then everything looked different. She realized that her mother had probably never condemned her for what had happened, as she had supposed, but had refrained from speaking about what had occurred because she felt that her daughter was too young to understand. She realized then what an influence the incident had had in shaping her personality, and for the first time she felt freedom from the yoke that had been a restricting influence in her life since her fifth year. She was conscious of a sense of freedom and confidence that grew each day and afforded her much relief and happiness. It was interesting to see the outward effect of her new sense of freedom in the popularity with other women that suddenly took the place of the previous condition of aloofness that her attitude had engendered.

It is such experiences as this that often result in so great a feeling of terror that they are pushed out of the field of consciousness into the lower level of the unconscious, where they continue to be the source of unexplained fears and other neurotic symptoms that indicate the imbalance that exists in the individual's power of emotional expression.

We have recently described [1] two cases where emotional experiences occurring at the age of seven years had aroused sex consciousness and had lain unrevealed for years, inactive as far as any constructive outlet was concerned, but fermenting internally and causing neurotic and antisocial symptoms. If such conditions as these could be recognized in children, it would be possible to guard against unconstructive emotional repressions and unnecessary feelings of shame and of inferiority that prevent the child's effective nature from developing in a normal, balanced way and his energy from finding normal constructive outlets.

Children are far cleverer than we realize, and their emotional life is well developed by the time they are first put to the breast. Watson has shown in his experiments on babies in the first few days of life the presence of anger, fear, and

[1] Three Cases of Larceny in Which the Antisocial Conduct Appeared to Represent an Effort to Compensate for Emotional Repression. By Edith R. Spaulding. MENTAL HYGIENE, Vol. IV, pp. 82-102, January, 1920; also *American Journal of Insanity*, Vol. LXXVI, pp. 303-19, January, 1920.

affection.[1] Whenever emotional experiences arise and undesirable habits form, they should be faced and corrected in such a way that the child may be stronger for the experience rather than handicapped by it. The knowledge of sex that is allowed to come through the promiscuous channels of chance experience alone is, as we know, exceedingly dangerous. If the child feels, however, that he is free to go to his parents with whatever is troubling him, no matter what its nature, it should be possible to prevent the evil consequences of such chance happenings.

Perhaps one of the most important phases of balance in the field of emotions is found in the expression of the affections. As much danger lurks in the repression and coldness of a stern New England household that makes it difficult for the child ever in later life to express himself freely as in the home in which the child is overladen with love of such an intense nature that he has difficulty in freeing himself from its bonds and in making adult adjustments in the realm of his affections in later life. Here, then, it is most important to keep the balance true, and while providing the child with adequate avenues for his demonstrativeness, to guard always against a too great intensity and a dependency that will prevent him later on from meeting successfully the demands that adult life will make.

There is to be maintained not only the balance between the physical and the mental, which has already been mentioned, but also between the emotional and the intellectual. Although the purely intellectual person and the purely emotional person may be recognized as fairly distinct types, still, through encouragement and conscious direction, the intellectual should be able to cultivate emotional activities and the emotional intellectual interests to an extent that would result in a more balanced and a saner expression of energy.

Another field of balance in the personality is that of what may be called opposing characterologic traits. Most important among these are the so-called, but we might say quite arbitrarily named, masculine and feminine traits. We see what we call masculine men and masculine women and

[1] Watson, Jennings, Meyer, Thomas. *Suggestions of Modern Science Concerning Education.* New York: Macmillan Company, 1918.

feminine men and feminine women. But do we realize how active the law of compensation is in keeping the balance even here? Do we realize how strong the feminine element is in the typically masculine individual, and the masculine element in the typically feminine individual? Furthermore, do we realize how often one trait has developed from an attempt to cover up or compensate for the other, which may be considered undesirable by the individual?

It is interesting to find in the following one of the best descriptions of this dualism of the individual, by Ralph Waldo Emerson:

"An inevitable dualism bisects nature, so that each thing is a half, and suggests another thing to make it whole; as spirit, matter; man, woman; subjective, objective; in, out; upper, under; motion, rest; yea, nay. . . . Whilst the world is thus dual, so is every one of its parts. The entire system of things gets represented in every particle. There is somewhat that resembles the ebb and flow of the sea, day and night, man and women, in a single needle of the pine, in a kernel of corn, in each individual of every animal tribe. The reaction so grand in the elements is repeated within these small boundaries. . . . The same dualism underlies the nature and condition of man."

On the one hand we find the aggressive instincts—domination, pugnacity, heterosexuality, sadism, etc.; while on the other hand we find the more passive instincts—submission, passivity, self-sacrifice, homosexuality, masochism, etc. Every individual, in order to obtain and maintain the greatest mental health, should have a constructive outlet for the amount of both of these characteristics in his mental make-up, which may quite possibly be determined to a great extent by elements in his physical make-up. In other words, he should have a realm in which he is supreme and another in which he is dominated. It has often been said that the best soldier makes the best general, that in order to rule wisely one should have learned to obey. In order to obtain the greatest efficiency one must make a satisfactory adjustment with authority and at the same time learn to wield it.

In the treatment of a mental patient, an attempt is frequently made to find the source of his repressed emotion, the

point at which his energy reached an impasse, in order that some constructive expression may be given it. In the type of personality that is often found in what are called the benign affective psychoses, the adaptation to authority has oftentimes been only too well made; the patient likes it too well and is perhaps too dependent upon it. In such cases the clue to the establishment of equilibrium is in cultivating constructively the more aggressive traits, in finding a field in which the patient is interested in doing something well, which can later be developed into a realm in which his responsibility is complete, a mature field that will help balance the immaturity through which, perhaps, he has attempted unconstructively to rule.

This balance of the masculine and the feminine, the hetero- and the homosexual components, is very interestingly shown in the two main characters in *The Jest,* recently played in New York. Two characters are portrayed—the first a soldier with a mercenary's aggressiveness, cruel, sadistic, amusing himself by decorating with pictures made with the point of his dagger the body of his enemy before he throws him into the river; the second a delicate youth, an artist by nature and by profession, who loves the beautiful and is terrified by the brutality and aggressiveness of the first character. In the life of the first, the greatest influence is not that of a woman, as might be expected from the pureness of the heterosexual type, but instead it is the love of a man, his own brother, which he himself says transcends all else in his life and is the greatest thing he has ever known. Moreover, it is the fact that he has killed this man, his own brother, that finally makes him lose his reason, after he had withstood without flinching terrible privation and great suffering and even the loss of the woman he had loved. Furthermore, in the life of the artist, obviously of the feminine, homosexual type, the great dominating energy comes from the love for a woman. Thus we find two portraits of human nature that show, in spite of the apparent pureness of type, a duality of nature in which there is a combination of the masculine and the feminine—the intensity of the one characteristic well balancing the extensiveness of the other.

Another important field in the balance of the opposing

characterologic traits exists in the realm of the imagination and the appreciation of the difference between an imaginary and a real world. Adler has described[1] the attempts of every child to reach his goal of grown-upness and power, and the difficulty that the neurotic child has in keeping his ideal of strength and perfect manhood in its true relation to the real and to the imaginary world, and in reaching it by constructively climbing rather than by too hastily jumping. The child may expend much energy unconstructively in his effort to become manly and to overcome his feelings of inferiority in what Adler calls a masculine protest—his mistaken protestation of masculinity.

Burrow has described[2] two distinct types of personality: one creative and intuitive, inspirational and constructive in the field of art; the other exact, deductive, mathematical, with objective tendencies. Our aim should be, however, we believe, to establish a balance with elements of both types in each personality, not making the proportions of each equal, but recognizing in each individual the possibilities of development of both types of characteristics. In the following of ideals the energy must be constructive—it must arrive somewhere. Every bit of creative energy must find outlet throughout the life of the individual, expressing itself in giving birth to ideas in art and literature, in scientific research, in industrial organization, in inventions of all kinds, as well as in the propagation of the race. Little can be accomplished without this creative element in any field except where automatic plodding alone is required. But, on the other hand, a certain amount of the same humdrum plodding is necessary to utilize the creative element, whether on the stage, in the studio, in the library, in the laboratory, or in the industrial field. It is therefore equally necessary for each individual to develop to some extent his power to do routine work, to adjust himself to the discipline of continuous effort. It is the lack of balance in this respect, the failure to make use of opportunities when they arise and to make adequate adapta-

1 Adler, Alfred. *The Neurotic Constitution.* New York: Moffat, Yard, and Company, 1917.

2 Burrow, Trigant. Notes With Reference to Freud, Jung, and Adler. *Journal of Abnormal Psychology,* Vol. XII, p. 161, August, 1917.

tions, that often causes those who have elements of genius in their make-up to become what are recognized as failures in the world, to become psychoneurotic through inability to adjust and to utilize the energy that they have.

As has already been suggested, the study of opposing characterologic traits might be carried on indefinitely. Many characteristics that are desirable in themselves become undesirable in their exaggerated forms. For this reason it is always desirable to establish a certain balance between each characteristic and its opposite extreme. The following grades will suggest the need of some such balance: self-assertion and humility; suggestibility and stubbornness; concentration and distractibility; loquaciousness and taciturnity; deliberation and impetuosity; optimism and pessimism.

The balance between work and play has been recognized since the days when Jack was make a dull boy, and yet the race, as well as the individual, is suffering from a lack of it. Surely this balance should be kept true in the early life of the child, since the habits of responsibility as well as the joy of living must be cultivated in the first few years if our children are to be prepared to meet situations in adult life and are not to have recourse to the neuroses as a way out of facing reality.

Patrick, in his interesting book on the psychology of relaxation,[1] maintains that war is the outcome of the lack of balance in the development of the individual that prevents him from giving sufficient outlet to his primitive instincts and to his childlike desires. One of the most important of these, Patrick points out, is the play instinct, which has such an important rôle among primitive peoples and among the children of our own race, but which oftentimes has but a small place in the adult life of our present-day civilization. This author believes that if international law and universal arbitration prevent wars between nations, there will be but the more civil strife, until a better balance in the life of the individual is maintained. The emphasis laid on recreation during the war in keeping up the morale of the army is an example of the

[1] Patrick, G. T. W. *Psychology of Relaxation.* Boston: Houghton Mifflin Company, 1916.

recognition of the importance of this balance in what may be considered the most strenuous of occupations. The community work that is developing now in time of peace as an outgrowth of the war activities is evidence of the recognition of its value in offsetting the restlessness of the reconstruction period. Industry has already shown this recognition in its effort to obtain through scientific management the highest efficiency of its workers. The Gary school system is another evidence of the appreciation of the same need.

In seeking for opportunities for personality development, the greatest number of resources is necessary in order to be able to select those activities that will best hold the interest of the individual. The constructive qualities of such activities may be estimated by weighing their egocentric with their social values. It is interesting to see what emphasis is given to helpfulness to other people in the organizations of Girl and Boy Scouts, which furnish such valuable outlets for the utilization of energy. Every trend in education that has as its aim the socialization of the individual is carrying out in the most desirable way the principles of mental hygiene and is a step toward the balance that is so necessary for mental poise.

To summarize what we have tried to express: If the equivalent of what has already been accomplished in other fields of preventive medicine is to be accomplished in the field of mental hygiene, and a sounder mental race is to be built up, the growth of our children must be watched, that a balance may be maintained in their personality development. Such a foundation should make for the most constructive expression of the child's energy and help him to utilize every opportunity to face reality and make adaptations that will be to his advantage. Above all, it will aid him in directing his egotistic energy into fields that will bear fruit for society at the same time that it is yielding individual returns. In order to accomplish this, he must learn to make assets out of liabilities and to utilize a little of the philosophy that has been handed down by poets and philosophers as well as by psychologists and psychiatrists. There is nothing particularly new in many of the ideas incorporated in this training, but society has been slow in making universal use of them and in realiz-

ing the true relation between personality development and mental disease.

It may be interesting to see what has already been written in other realms besides that of psychiatry on the desirability of facing reality. It is refreshing to remember that Browning would have us

> "Welcome each rebuff that turns earth's smoothness rough,
> Each sting that bids nor sit nor stand, but go!
> Be our joys three parts pain!
> Strive, and hold cheap the strain;
> Learn, nor account the pang; dare, never grudge the throe!"

And also that Emerson says: "Our strength grows out of our weakness. Not until we are pricked and stung and sorely shot at awakens the indignation which arms itself with secret forces. A great man is always willing to be little. Whilst he sits on the cushion of advantages he goes to sleep. When he is pushed, tormented, defeated, he has a chance to learn something; he has been out on his wits, on his manhood, he has gained facts; learns his ignorance; is cured of the insanity of conceit; has got moderation and real skill. The wise man always throws himself on the side of his assailants. It is more his interest than it is theirs to find his weak point. The wound cicatrizes and falls off from him, like a dead skin; and when they would triumph, lo, he has passed on invulnerable!"

PUBLIC-SCHOOL CLINICS IN CONNECTION WITH A STATE SCHOOL FOR THE FEEBLEMINDED

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AN out-patient clinic has been held weekly at the Massachusetts School for the Feebleminded, at Waverley, Massachusetts, since 1891.

Five years ago, at the urgent request of the public-school authorities, the work was extended, and monthly mental clinics were established in the northern, central, and southern parts of eastern Massachusetts, in the cities of Haverhill, Worcester, Fall River, and New Bedford. Special clinics have been held also at Newton, Taunton, Hyannis, and Falmouth, to examine selected groups of school children.

Only the clinics held in connection with the public schools will be reported on here. The cases seen at the clinics held at Waverley differ somewhat in character from those seen at the school clinics. The latter are mostly children of school age, without special character defect, selected for examination because of backwardness in the grades or truancy, while a larger number of cases presented at the institution clinic are border-line cases that have become problems on account of social or moral delinquencies.

The organization and the method of conducting these school clinics are similar to those used at the clinic at Waverley, and the methods of diagnosis are the same.

The staff of examiners visits the towns above mentioned monthly. The staff of this traveling clinic consists of:

1. A psychiatrist, who directs the clinic, gives the physical examinations, makes the final diagnoses, and interviews and advises the parents and friends;
2. A psychologist, who does the mental testing, interprets the findings, and notes special defects;
3. A teacher, who makes a school examination in reading, writing, arithmetic, spelling, language, and geography, to determine the actual

grade work the child is able to do, and who asks the questions to determine the child's practical knowledge;

4. A school nurse or other competent person, who looks after the children to be examined, transfers the children from one examination to another, and assembles the records.

The psychiatrist, psychologist, and teacher are members of the staff of the Massachusetts School for the Feebleminded, and they are assisted by members of the staff of the state hospitals at Taunton and Worcester. The nurse is furnished by the school department of the city in which the clinic is held.

In obtaining the information necessary to make diagnoses, the Waverley "Ten Fields of Inquiry," described in Dr. Fernald's *Standardized Fields of Inquiry in the Diagnosis of the Higher Grades of Mental Defect,* are used.

These are:

1. Physical examination
2. Family history
3. Personal and developmental history
4. School progress
5. Examination in school work
6. Practical knowledge and general information
7. Social history
8. Economic efficiency
9. Moral reactions
10. Psychological examination.

The family history, the personal and developmental history, the history of school progress, the social history, the report on economic efficiency, and the history of moral reactions are secured in advance by a social worker, a school nurse, or some other person who is qualified to obtain the required facts without antagonizing the parents and who can make them feel the necessity of supplying such information in order that their children may be better understood and helped. This information is highly confidential. Much tact is required, and this work should be done only by experienced people; otherwise it is either impossible to obtain the facts or their purpose is misconstrued.

In a school clinic it is not always possible to secure full histories, especially family histories and personal and developmental histories, but the most important facts can usually be

obtained. In the case of the family history, it is possible to get information about the immediate family, as it is often a matter of general knowledge whether or not the mother and father, brothers and sisters have been or are insane or are considered up to the average in mentality.

Satisfactory personal and developmental histories are difficult to secure, especially from non-English-speaking people. Here again, however, many important facts can be elicited, such as personal habits, age at which the child began to walk, talk, and cut his teeth, etc., history of convulsions, etc.

The economic history is not of great importance in the case of younger children.

The physical examination, the examination in school work, the examination as to practical knowledge, and the psychometric measurements are made by the staff at the monthly clinics.

Complete records of every case examined are kept by the Massachusetts School for the Feebleminded, by the state hospital that assists at the clinic, and by the school department of the city where the clinic is held, a permanent record thus being placed on file for possible future reference.

The splendid coöperation of the public-school departments in the various cities has contributed greatly to the success of these clinics. Without this coöperation, it would be impossible to derive the maximum benefit from a clinic of this kind, or even to continue it. In these clinics, the school departments have taken the local responsibility, provided a place for holding the clinic—usually in the school administration department or in some centrally located school—made the primary selection of cases to be examined, attended to securing the histories, notified the parents and friends, and supervised the carrying out of the advice given, such as:

Place in special class
Place in open-air school
Have Wassermann test
Change teachers
Change environment
Place in the country
Have adenoids and tonsils attended to, etc.

The school authorities have been most appreciative of the

help of the clinic. Recently one of the assistant superintendents of schools, when asked of how much value she felt the school clinics had been to the school departments, answered, "Of inestimable value, and you can doubly underscore that."

Up to February, 1920, the number of examinations made in these various school clinics was 1,155:

Male	774
Female	381
Total	1,155

Of these 1,155 cases, 1,070 were first visits, 81 were second visits, and 4 were third visits.

Of the 1,070 children examined, the following general diagnoses were made:

	Total	Male	Female
Feebleminded	783	522	261
Not feebleminded	146	101	45
Possible psychosis	6	5	1
Diagnosis deferred	104	77	27
No diagnosis on account of insufficient records	31	18	13

It takes on an average about one hour to examine a case thoroughly.

While the majority of the cases diagnosed as feebleminded were of the ordinary types of mental defect—idiot, imbecile, or moron—in these groups many special types have been presented:

Epileptic	22
Cretin	4
Spastic paralysis	4
Mongolians	7
Hydrocephalic	4
Microcephalic	6
Chronic lenticular degeneration with mental deterioration*	6
Pseudo-muscular hypertrophy	2
Congenital syphilis	2

* For an account of these cases see A Report of Three Cases of Chronic Progressive Lenticular Degeneration with Mental Deterioration. By John Jenks Thomas. *The Journal of Nervous and Mental Disease*, Vol. XLVII, pp. 321-332, November, 1917.

In making diagnoses of the mentality of the younger children, it has been necessary to use some caution. If there has

been any doubt as to what the ultimate development would be, diagnoses have been deferred and the advice given that the child be returned in six months or one year for reëxamination.

To illustrate, a Swedish boy was brought to one of the clinics on account of his extreme backwardness in school. He was eight and a half years of age, had attended school for two years, and was unable to do the first-grade work. Psychological tests showed his intelligence quotient to be 65. However, his practical knowledge and performance tests were nearly up to age. He spoke English, but heard only Swedish spoken in his home. In his case it was thought best to defer the diagnosis and place him in an ungraded class for special help. In six months he was returned for reëxamination. His I. Q. was then 88. He had learned to read well in the Third Reader, could do third-grade arithmetic, and was able to go into the third grade and keep up with its requirements. Apparently this boy had been hampered by language difficulty or inability to think in the English language, and the special class gave him just the help he needed.

On the other hand, one boy nine and a half years of age, who had an I. Q. of 85, was admitted to the Massachusetts School for the Feebleminded. The diagnosis of mental defect in his case was made from the evidence presented of mental defect in the family, poor school progress with good school advantages, and inability to adjust himself socially. He has been at the school for four years. He now has an I. Q. of 67, showing that he reached his maximum development at an early age.

While these are exceptional cases, they illustrate some of the pitfalls in diagnosing the younger children.

One fond mother brought her three children for examination, saying that she was much worried about them. She had been reading a great deal about feeblemindedness and delinquency, and she felt sure that there was some serious defect in her children; they behaved so badly at times. Much to her relief, all the children were found to be normal mentally.

A middle-aged kindergarten teacher came in with one of her pupils to have him examined. She had made a diagnosis in advance. She informed us that she knew the child was feebleminded; he would not keep his paper straight on his

desk, he never answered questions or took part in the games, and he was generally stupid. After talking with the child for a few minutes, to become acquainted, one of the examiners found that he was interested in Charlie Chaplin. He described accurately a moving picture he had seen, much to the amazement of his teacher, who said she had never heard him talk so much before. Mental tests showed the child to be up to normal. Needless to say, a change of teachers was recommended, and upon last report he was keeping up with his grade. In fact, this new teacher said that he was one of the best boys in her class. This was simply a case of maladjustment.

While these clinics were established primarily in connection with the public schools, cases for examination from any source have been welcomed. Children and adults have been sent in by the courts, the Children's Aid Society, the Children's Friend Society, the Society for the Prevention of Cruelty to Children, the Door of Hope, the Commission for the Blind, boards of charity, private individuals, clergymen, parents, and friends.

A diagnosis is of no great value to the people concerned in caring for a child unless some remedy or help can be suggested. The giving of advice is one of the most important functions of the clinic. While every case must be considered individually, we have given such general advice as the following, varying it according to the age, sex, and mentality of the patient:

For the idiotic class, suggestions have been given in regard to active and passive exercise, aids in learning to walk—such as the baby jumper, walking stool—the kind of toys to use, etc. The importance of regular habit training has been emphasized. Information has been given as to how much to expect in the way of mental development, and the impossibility of school training for this type of child has been explained. The possibility of institution care if the burden should become too great in the home has been discussed.

For the imbecile type, we have dwelt upon the futility of trying to teach the boy or girl school work beyond his or her mental age and have advised that the training should be along the lines of industrial work, graded to suit the mental and

physical age—elementary handwork, sense training, etc. for the younger children; for the older children, woodwork, weaving, learning to handle tools, work in the gardens, sewing, simple household tasks, knitting, crocheting, etc. We have further advised that all of this training could best be obtained in the special classes or if necessary in an institution.

For the moron, we have emphasized the importance of special-class training or institution training, according to whether they were "good morons" or "bad morons" and according to home conditions, dwelling upon the fact that, if right habits of living and habits of industry are acquired during the adolescent period, it is probable that the boy or girl will succeed later.

Parents are always urged to accompany the children to the clinic. When interviewed, they are apt to say that the reason that their child is not progressing in school is because the teacher does not give him or her sufficient attention, or that she is not a capable teacher, or that she has taken a personal dislike to the child. When it is demonstrated that the child has reached a certain physical age, but that the mental age has not kept pace with the physical age, the parents are then asked to compare the feebleminded child with the normal members of the family. They will finally acknowledge that they have known for some time that this child was backward, but that they had not thought of it in this way until it was explained to them. A chart which graphically illustrates the fact of the child's backwardness is very useful in demonstrating to the parents. After acknowledging the child's condition, their minds seem to be relieved; their confidence is gained, and they are willing to coöperate in any way that may be suggested. If institution care is advised, a description of the institution training is given and an invitation is extended to visit the institution if possible.

In some cases, parents are making themselves poor trying this treatment and that treatment, in the hope that some "cure" may be found. It is a difficult task to tell them that their hope is vain, but, by telling them this, one may prevent the useless expenditure of hundreds of dollars that can be ill-spared from the rest of the family.

In addition to advice given to the parents, courts have been

advised as to the responsibility of delinquent boys and girls for their delinquency. Also, school authorities have been advised in regard to giving work cards. In cases of feebleminded boys and girls fourteen, fifteen, or sixteen years of age, if the clinic will say that they have reached their maximum development in school work, and they have attended school faithfully for seven years, work cards are allowed. A boy or girl who is strong and healthy and well developed physically, and who has received all the benefit possible from special-class training, is better off in some well-supervised employment; more of their time is occupied and they have less opportunity to acquire habits of idleness and become delinquent. In this way, too, they become economic assets to the family.

Of the 783 cases diagnosed as feebleminded, institution care was advised in 220 cases. One hundred and two cases have been admitted to the schools for feebleminded—Wrentham and Waverley. This means that institution care has been considered necessary in 28 per cent of the cases found to be feebleminded and gives some idea of the number of feebleminded who must be cared for at home.

The functions, then, of a school clinic are:

1. To benefit the child
2. To serve the schools
3. To serve the community.

The clinic benefits the child by helping the teacher to understand the mentality of the feebleminded pupil and the kind of training he or she needs.

It serves the schools

1. By selecting the children for the special classes, thus relieving the grade teachers of the burden of the feebleminded in their classes;
2. By differentiating the children who are retarded through sickness, poor school attendance, frequent changing of schools, physical defects, etc., but who have normal native ability, from those who are feebleminded;
3. By taking out of the school and the special classes the feebleminded who are not capable of making more progress;
4. By preventing the special classes from becoming filled up with disciplinary problems, instead of with those who properly belong there;
5. By examining truants and differentiating those who are responsible from those who are truant on account of mental defect and consequent lack of interest in the grade work;

6. By advising home or institution care for those who are of too low mentality to profit by special-class training (I. Q. below 20-25);
7. By showing the need for special classes and promoting better feeling in regard to them.

The school clinic serves the community

1. By advising and instructing parents as to home care and supervision;
2. By examining any case of suspected mental defect for courts, social agencies, physicians, or from any source whatsoever;
3. By helping to take out of the community the feebleminded who need institution protection and training and who may become a menace to the community or be menaced by conditions in the community;
4. By assisting in making a census of the feebleminded in the community for future reference.

With the exception of a few idiots, all feebleminded children pass through the public schools at some time. If systematic examination of all the retarded children in the public schools could be made, in time there would be a complete registration and census of all the feebleminded.

Already Massachusetts has passed a law requiring a mental examination of all children three years retarded. Partly on this account, the need for more school clinics has become so pressing that the work has been broadened and a traveling clinic is now being organized by the Department of Mental Diseases.

The staff of experienced examiners will spend their entire time in this work. They will visit various sections of the state, in turn, making surveys of the schools in these sections. This is part of a constructive program for better care of the feebleminded of the entire state.

The benefit of a school clinic is not all on the side of the schools and the community. It is a distinct advantage to an institution staff to come in contact with these school problems and this number of undiagnosed cases. The institutions and the schools are brought in closer harmony and, working together, they can give the feebleminded the care and training that are their just due, because they have come into this world seriously handicapped.

THE MENTAL HYGIENE REQUIREMENTS OF A COMMUNITY*

Suggestions Based Upon a Personal Survey

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MENTAL hygiene is one of our great public-health interests, but unlike other matters of public health, it is not represented as yet by departments of state or of the national government. Mental diseases and mental deficiency are less clearly understood than are smallpox and tuberculosis. There is need for continuous work on the part of the apostles of mental hygiene. In the nineteenth century, Dorothea Lynde Dix, by her appearances in behalf of the mentally ill before legislatures, established many state hospitals. These hospitals in many states are now sadly in need of improvements. The scope of their activities needs to be widened. The patients in some of these hospitals are actually in need of treatment. Furthermore there are in some states many mentally diseased persons in jails and almshouses who should be in hospitals. And the continual complication of many social problems demands the segregation and special training of feeble-minded criminals, prostitutes, and paupers.

When an appeal for advice comes from a community in which these conditions prevail, it comes from the enlightened few who have obtained a vision of the better things possible for the community. They see the need of real treatment for those who are mentally ill—and for all who are mentally ill. They see the need of diagnosing mental conditions in order to get at the fundamental difficulty of many problems of delinquency and dependency. They see the need for thoroughgoing, scientific work in the way of preventive medicine in the field of mental hygiene.

* Read before the Mental Hygiene Division of the National Conference of Social Work at New Orleans, April 21, 1920.

The people generally are not aware of the cruelty and injustice done to individuals with mental disease in jails, almshouses, and some hospitals. The people generally do not realize that a saving could be effected, not only in human happiness, but in human efficiency, by scientific administration in the fields of mental diseases and mental deficiency. The people generally do not know that much crime is committed by persons with the minds of children. They do not know how rapidly feebleminded criminals and prostitutes increase. They do not realize how feebleminded children impede the work of education and of child care. They do not know how the clinical aid of psychiatrists would simplify many court and charity problems. They do not know that much expense could be saved by proper clinical facilities.

For the enlightenment of the many, for the purpose of getting necessary legislation and funds, and in order to cultivate a public sentiment that will enforce such legislation, the community requires two things. It is first necessary to ascertain facts in the community itself, in order to demonstrate on the ground the saving to taxpayers and the conservation of citizenship which it is possible to make by making effective proper mental-hygiene measures. This ascertainment of facts and setting forth of a plan for improvement we call survey work.

It is found very necessary to follow up the survey work with educational work. Just as every industry has to develop selling facilities in order to make a market for production, so is it necessary to sell the idea of economy and conservation. A proper dissemination of the facts obtained in the survey will sell the plan and effect legislation. It is necessary to proceed from the nucleus of informed citizenship from which the invitation came and to organize in ever-widening circles a popular demand for the enforcement of the principles of mental hygiene in the community.

Having been in the field in response to some of these calls from communities, I have been asked to state some of the conditions as I find them. First, let us begin with the treatment of the patients in state hospitals. Here, if anywhere in the whole community, we should expect to find the laws of mental health observed. Many of these hospitals were established

by legislatures in Southern states in answer to the urgent solicitations of Dorothea Dix. It is a sad commentary upon the inherent conservatism of the human race to find on visiting some of these hospitals how little there is in their present organization to justify the high aims with which they started. In one of these Gulf states I know of a hospital with a population of about 1,600 patients. The staff of this hospital is composed of the superintendent and three assistants. This is a totally inadequate number of medical men to do the work required, but a more important consideration in this connection is that no one of these four physicians has ever had training in the field of psychiatry. They know nothing more of the pathology of the human mind, or even of normal psychology, than they have been able to pick up in the ordinary avenues of human intercourse.

There is no classification of patients, dividing those who need active treatment from those whose demand is only custody. There is no scientific case study, and case histories, as a matter of course, lack the contributions that could be made by adequate psychiatric studies of the patients. There is no equipment for the employment of patients as a means of restoring their minds to normal efficiency. Hydrotherapeutic apparatus, installed years ago, has not been used for a long time. There is no real treatment. Of course some patients do recover. I was recently told of the recovery of a man to whose mother a physician told me he had written a hundred letters stating that there was no possible chance of recovery. I judge from the meager description given that the case was one of manic-depressive insanity complicated by drug addiction. It may have been a case in which a better trained psychiatrist would have mistaken the diagnosis and the prognosis; but it is clear that the lack of psychiatric training in the staff of such a hospital is utterly without excuse, and the community that allows its mentally diseased patients to be deprived of the benefits of such training is in need of an awakening. It needs to be shown that it is incurring great expense in suffering countless cases of mental disease which could be prevented by the application of knowledge readily available.

In this hospital the patients are crowded—so crowded that when I telephoned from an outlying county, where I had found

an actively hallucinated patient in jail, to ask if she could not be admitted, I was informed by one of the physicians that the patient was really as well off in jail as she could be in their crowded wards. As far as the question of space was concerned, his answer was correct, but of course the patient would have been better off under the observation of a physician than in the care of the sheriff, even though the physician had 400 other patients to look after and was not himself a psychiatrist.

The physician's statement is an indication of the complete lack of applied psychiatry in this state, even in a hospital built and maintained for the purpose of giving expert aid to sufferers from mental disease.

In the community which this hospital serves, examination by a physician before commitment is not required—in fact, there is no examination of the patient whatsoever. The responsibility for commitment rests with the chancellor or chancery clerk, who calls together six men, professional jurymen hanging about the courthouse for such service, who usually agree with the view of the clerk. The patient, after lying in jail for some time, is conveyed by the sheriff to the hospital. Recently many negroes were lying in jail because the hospital was too crowded to receive them.

Many scores of feebleminded complicate the work of this hospital for mental disease because the community has no institution for the proper care and training of the feebleminded.

In the New Orleans Hospital for Mental Diseases, I find many patients that should have been received months since in the state hospital. They have been allowed to remain on account of the crowded condition of the state hospital. The City Hospital for Mental Diseases is designed to be a psychopathic hospital, a receiving station for the city in which many acute cases might be recovered and the formality of commitment avoided. The majority of patients whose illness promises to continue for several weeks or months should be transferred and treated at the state hospital. The physician in charge informed me that there are upwards of 500 patients in the city of New Orleans who are in need of treatment at the state hospital or at an institution for the feebleminded, but who have been discharged from the city institution simply

because of lack of capacity both at the city institution and at the state hospital.

In some of these Gulf states there are many patients with mental disease held in jails and almshouses. In one state I have seen a negro woman in a cage-room in a jail with twelve men. In another jail an actively excited negro woman had torn out the water fixtures in her cell, had yelled all night long to the discomfiture of the neighbors, and was making erotic exhibitions to men in a neighboring cell. In another jail a white woman was properly confined in a clean room in isolation from other occupants of the jail, but her sole attendant was the jailor, a man. Another negro woman, who would not keep her clothing on, was in constant view of two white men and a negro. In a Louisiana parish jail two men work in the kitchen where women of the jail, three of them insane, are confined and are practically alone with these women all day long. Another parish jail confined one negro woman, two negro men, and one white man practically in the same room. In another parish a woman mentally ill was lodged in a cell plainly in view of men in other cells and was making obscene invitations to them. In most of the parish jails where female insane are confined there are no female attendants, and when these inmates are bathed, the jailor himself sees to it.

Jailors of county and parish jails have no comprehension of the proper management of the mentally diseased. One told the visitor that at first he thought the crazy were very funny. One jailor had recently found the floor of two rooms of the jail torn up and the boards broken into kindling wood by an insane inmate. He heard the noise during the night, but he was afraid to go to the man. In two parish jails violently insane negroes were regularly roped and strapped every day or two and thrown into a bath tub while the cell was washed out. In one of these cases an insane woman was the daily witness of this procedure as well as of an insane man who persistently refused to wear clothing. The strap and the blackjack are freely used for the discipline of insane inmates in jails.

In the parish and county jails of Louisiana and Mississippi, the patients with mental disease are frequently found in cramped quarters and without furniture. In one parish jail, five negro women, three ill of mental disease, were found con-

fined in a room seven by ten feet. In this room were also a bath tub and a commode. There were no chairs in the room, but there was one couch. At night, the visitor was informed, this was carried out, and the five women slept upon the concrete floor without pads or mattresses. The room was indescribably dirty. Similar conditions have existed in the recent past in more than one Mississippi county jail. One patient who had been in jail three months and was recovering had had but one bath in that time.

There is no real treatment of the mentally sick in jails even when the coroner takes a hand. In one instance an epileptic boy in a parish jail who had been confined eight months was kept continuously doped by the coroner's order, "to keep him from raising the devel," as the jailor said. In another parish jail the regular practice is to turn the hose on those who as a result of their illness are boisterous. I have seen many patients afflicted with dementia praecox of the depressive type who, because of their mental condition, refused to eat or speak confined in jail for weeks, although the jail of course had no facilities for feeding them and securing other necessary health facilities for them.

In one of the state hospitals in Mississippi, there are upwards of 130 feebleminded persons. Large numbers of these are children. One boy of sixteen, with a mentality of eight years, has been in the hospital, confined in a ward, for over a year. He is a half orphan and was in the care of a child-placing agency, but the agency could neither place nor keep him. He persisted in running away. Many such children are thus improperly confined without any opportunity for recreation or training. The older feebleminded, not being properly trained to work, are no more nearly self-supporting than are the other patients in the hospital.

In all these Gulf states, there are feebleminded children in orphanages. One Alabama orphanage is reported to have three females, thirty years of age, who are retained simply because it would be heartless to turn them out, as they have no ability to care for themselves. In two orphanages in Mississippi, with total populations of about 270, I found, in a thoroughgoing mental survey, over 30 children who are unquestionably institution cases because of their meager mental

equipment. There are 1,500 children in orphanages in New Orleans. One of the largest of these orphanages (250 boys) is being surveyed at the present time. Dr. Maud Loeber and I have found up to date about 20 per cent of the boys so poorly equipped in intelligence that we have no reasonable doubt that they must be made permanent wards of the state in order to keep them out of danger and to prevent them from doing harm to society, either as parasitic dependents or as offenders.

The populations of industrial schools and reformatories present numerous examples of feebleminded persons. In the four Alabama industrial schools, Dr. W. D. Partlow and I found last year 129 feebleminded children in a total population of 654, or about 20 per cent. At the Mississippi Industrial and Training School, with a population of 128 children in October, 1919, I found 2 girls and 8 boys feebleminded and 5 others of border-line intelligence. In February, 1920, at the White Waifs' Home in New Orleans, with a population of 64 boys, I found 13 feebleminded and 4 of border-line intelligence. Over 20 per cent of these boys are so defective that there is no reasonable chance for them to go straight without guardianship of some sort, and 6 per cent more are of such doubtful equipment that they need guardianship until they demonstrate by their behavior that they can manage successfully for themselves.

In the public schools of Jackson, Mississippi, in a mental survey carried out by group intelligence tests, followed up by Stanford-Binet examinations of all low-scoring individuals, I found 15 feebleminded children in a school attendance of 1,555 white children in the grades. Eight other feebleminded white persons of school age were found in the city.

Feebleminded are found in county and parish jails wherever any considerable numbers of such populations are surveyed. Forty-three county jails of Mississippi had aggregate populations of 255 at the times visited. Fifty-three of these prisoners had been committed to hospitals, but remained in jail because of the crowded condition of the hospitals. Besides these, eight others were found to be mentally ill, though they had not been so adjudged by juries. Forty-four of the prisoners were feebleminded. This number is 23 per

cent of the total proper jail populations visited (not committed as insane). Two of these were murderers and several were guilty of most beastly sex offenses. Such facts ought to awaken any community to the necessity of state provision for controlling those who cannot be expected to control themselves.

I have visited 38 county poor farms in Mississippi, with aggregate populations of 385 at the times of visits. Of these 385 persons, 141—well over one-third of the total number—were found to be paupers because they are feebleminded. Many of these had been born at the poor farms, some of incestuous relations between brothers and sisters. Many others have been married and have brought forth children at the poor farm. Still others, of course, have borne illegitimate feebleminded children while dependent upon the county for food and shelter. One of these, a middle-aged white woman, has borne many children, some white and some black. She is able-bodied, but in mentality ranges about six years. One poor farm shelters an old woman from whom have been taken a daughter and a granddaughter, both illegitimate and feebleminded, as she herself is. In this same poor farm are two sisters and a brother, paralyzed and feebleminded syphilitics. Another poor farm has twin sisters and a brother, all low-grade imbeciles, representatives of a family of eight feebleminded children born to the same parents.

In August, 1919, 101 white male convicts were examined at the Mississippi State Penitentiary. After thoroughgoing mental examinations, I rated 19 of these men as feebleminded. They ranged in mental age from 5.2 to 9.5 years. Others, even though of less than ten years mentality, I rated as of borderline intelligence. Clearly 20 per cent of these white men have not the intelligence upon which reformatory treatment can be expected to have the desired salutary effect.

Over 600 negro convicts, surveyed by means of a group intelligence test, and their performances compared with the performances of negro children in the public schools, present results which warrant us in classing about 40 per cent of them as feebleminded. Such a fact certainly gives pause to any sociologist considering the economy and efficiency of our present method of reformatory treatment. These convicts are

most profitably employed at cotton raising. But they are pardoned and released just as if they were reformed. Such facts as have been obtained in these states of Alabama, Mississippi, and Louisiana clearly indicate the need of a wide dissemination of the facts themselves in order to arrest the attention of thinking people and to arouse thought in regard to social matters in the unthinking. Such facts can and should be used for the further organization of that sentiment in the community and the state which led to the invitation for the extension of aid to them in the realm of mental health. When a state society for mental hygiene exists, such facts as these should be utilized in an active propaganda for extension of membership and a widening of influence for further educational work.

It is most important to secure this community organization in order to effect legislation. Members of a legislature naturally listen to their constituents with a different degree and kind of attention from that which they give to some one from another state, no matter how expert he may be in the field represented. For securing appropriations and needed changes in statutes, it is, therefore, most important to have local apostles burning with zeal for the organization of social agencies for the diagnosis, treatment, and prevention of mental disease and deficiency. Existing organizations can often be utilized for this purpose. The institutions improperly burdened with the feebleminded and the mentally ill will themselves ardently advocate proper provision for these classes. The federations of women's clubs, too, generally have a keen appreciation of the waste, both of taxpayers' money and of citizenship, caused by the present unscientific and poorly financed methods of administration—or lack of administration—for the mentally sick and the feebleminded. They also appreciate readily the great field offered for preventive work and advocate proper administration for these classes.

To such agents it is possible to demonstrate that directly and indirectly the state is spending more money on the criminal insane and those dependent because of mental illness—and accomplishing nothing in the way of prevention or constructive work thereby—than would be required to treat the mentally ill adequately with a certain return assured and to

segregate and train the feebleminded, thus obtaining the benefits of their productive work and avoiding their parasitic progeny. It is easy to show such persons that by preventing a man from acquiring syphilis in middle life and dying of paralysis after ten years of hospital care, they can save not only the cost of the ten years' care, but also his productive power for thirty years. By convincing these leaders in the community of the economies to be effected by rational preventive work, one becomes indirectly an educator of the lawmakers themselves.

In a state where one can even to-day hear on the floor of the House of Representatives the statement that state care of the feebleminded is not only futile, because no one can successfully diagnose mental deficiency, but that, even if practicable, it would be unsafe because it is an unwarrantable interference with personal liberty and an undemocratic drift toward socialism, there is clearly need for such educational work. When one hears a representative maintain that there are driveling idiots in the best of families and that, therefore, feeblemindedness is so all-pervasive that it is a hopeless task to undertake preventive work in this field—furthermore, that such a world leader as Abraham Lincoln would probably have been diagnosed as feebleminded when a boy—one is almost overwhelmed with the density of ignorance prevailing amongst lawmakers.

In a state where patients are crowded together in the state hospital so that it is no better a place for the mentally ill than a jail, according to the statement of one of the physicians of the hospital, I have heard a state senator arguing against an insanity bill offered by request by a group of experts and boldly maintaining that after a thoroughgoing investigation of the care of the insane of other states, a commission recently reported that the insane in his state were cared for quite as well as in any other state in the Union.

In such audiences one is again impressed with the magnitude of the community requirements in mental hygiene. The fields are indeed white unto the harvest. There is a tremendous need for the dissemination of light in dark places. The people need to be shown how to treat the mentally ill and the feebleminded, as well as how to economize in the management

of social problems and to conserve and improve productive citizenship. One sees that the requirements of the community are by no means limited to getting good insanity laws and good mental-deficiency laws upon statute books and adequate appropriations for the care of these classes. One sees that really the first requirement is the education and information of the people along the lines of constructive sociology. Good laws cannot amount to much in communities where there are such ignorant and demagogic representatives and senators.

One of the greatest aids in this field of constructive educational work is a psychiatric clinic. The planting of such a social-service station in a community will serve as a perennial demonstration of the need of psychiatric service in the solution of social problems as they come to police officers, courts, charity organizations, schools, and child-helping institutions. In communities where persons like the representatives and the senator above referred to exist in such large numbers that it is impossible to secure proper institutions properly furnished with funds to deal with cases involving mental pathology—with questions of mental hygiene at the root of social difficulties—it is important to establish such clinics as continual demonstrators of the need for these state facilities. Such clinics, properly organized by private charity, will soon demonstrate state facilities to be public necessities. They will also demonstrate to the doubting Thomases the real economy of community care of all problems of mental disease. They will demonstrate the wisdom of preventive measures in this field as well as in public-health matters generally.

Community requirements in mental-hygiene matters are, then:

1. A survey of important elements in the management or mismanagement of mental-hygiene problems;

2. Organization of the enlightened for the extension of their sphere of influence;

3. The establishment of local clinics for the purpose of rendering first aid in mental-hygiene problems as they occur and for the purpose of continuing the demonstration of the need of real constructive work in this field of public health in order to diminish the incidence of these problems in the future;

4. Aid in securing such appropriations and statutory provisions as are possible for state administration of care directed to the recovery of mentally afflicted patients, to the prevention of nervous and mental diseases, and to the diminution of the birth rate of the mentally defective.

These requirements cannot be set forth in a logical or chronological order. Each is a part of the others. All these lines of activity must be carried on simultaneously. Real improvement in the administration of mental-hygiene matters in a community can proceed only from an enlightened public sentiment which understands the reasons therefor.

THE INDUSTRIAL COST OF THE PSYCHOPATHIC EMPLOYEE*

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IN these days when production is a factor in the many problems that beset society, I wish to call attention to a source of waste in industry through psychopathic individuals. In pre-war days manufacturers were turning their attention to a number of systems the purpose of which was to increase the efficiency of their factories. They found that the penalty incurred in allowing any portion of their machinery to remain idle, and, in so doing, deteriorate, was lessened production and thus increased cost. This increased expenditure not infrequently was so heavy as to spell failure for a number of concerns.

In spite of the amount of time, money, and energy employed in this efficiency campaign, the results were proportionately meager, largely because the same attention that was given to capital was not so systematically applied to labor. I have often wondered what became of the man Schmidt, whose labor output, Taylor, the father of the efficiency movement, raised from something like two to twelve tons of pig iron a day. Nobody seems to have made a scientific study of the effect of the efficiency system on the laborer, although labor's resentment against it is outspoken. It took such an event as the World War to bring to men's notice, not alone the fact that they had been ignoring the idler and eliminating the inefficient, but also that the product even of these misfits was of value. But there is also a social aspect of this problem—namely, the reaction of the idle or inefficient worker upon the community in which he lives; and it was this aspect that was ignored in a policy that forced the idler back onto a community where he had to be supported either directly or indirectly by the workers.

* Read before the Mental Hygiene Division of the National Conference of Social Work, New Orleans, April 19, 1920.

The war's demand upon men made it necessary to supplement the efficiency campaign by another that trained the inefficient and forced the idler to work. At present there is such a shortage of labor that it seems unlikely that unemployment or competition in jobs will arise for years, but rather that there must soon be a redistribution of the available labor supply.

In helping psychopathic individuals towards social adjustment, the mental-hygiene worker is frequently confronted with a very difficult problem in finding work that is consistent with their abilities and their personal peculiarities. Not infrequently the individual's rehabilitation rests upon intelligent help in his vocation, not alone in the finding of employment, but in the way of encouragement in keeping at it. It has frequently been our experience that if the mental-hygiene worker does not explain to an employment manager the peculiarities of her patient, she is accused of insincerity. If she does explain, the chances are that the man will either be refused employment or else discharged as hopeless at his first manifestation of difficulty. Instead of giving him more than an average chance, he is often given less. So long as employment managers are ignorant of how to deal understandingly with the psychopathic employee, the mental-hygiene worker prefers to run the risk of a charge of unfairness rather than put into the employment manager's hands a tool that he does not know how to use and often misuses. An employment agent recently telephoned my office regarding a patient whom I had sent to her, saying, "I couldn't bother with a person like that. He got on my nerves." The irritating factor in the case of this patient proved to be the frequency with which he returned to ask for a change of employment.

By the term psychopathic employee, we mean an individual whose vocational failures can be largely attributed to defects in his personality, usually due to bad emotional methods of adjusting himself to his environment. Dr. Adler,[1] after a study of one hundred such cases, reported that "the treatment of their unemployment must be guided by a knowledge of their tendencies, so that environment, on the one hand, can be suit-

[1] Unemployment and Personality—A Study of Psychopathic Cases. By Herman M. Adler. MENTAL HYGIENE, Vol. I, pp. 16-24, January, 1917.

ably influenced or chosen for them, and that the individuals themselves may be trained to counteract their impulses to some extent." The following cases have come to my personal attention and have been selected as examples largely because of the prominence of their difficulties in vocational adjustment. Their social inadequacies manifested themselves in such difficulties as army S. C. D.[1] begging, estrangement from relatives, excessive borrowing, friendlessness, grafting, sexual difficulties, improvidence, irregular employment, panhandling, quarrelsomeness, vagrancy, and suicidal threats.

Case 1.—Patient is an American, twenty-six years old, single. Diagnosis—constitutional inferiority. He left school after completing the seventh grade, and after six months at a business college, left home to go to work. His first position was that of a clerk in a newspaper office, where he stayed two and a half years, the longest time he has ever spent at any one place. Although he was capable of earning good wages in his various subsequent positions, he seldom stayed long enough to do so. In 1915, while in the service of the United States Army, he was thrown from a horse and rendered unconscious for a few minutes. He received treatment for one year at St. Elizabeths Hospital in Washington, D. C., where it was said that he had sustained no organic injury and treatment was directed toward giving him a better equipment with which to secure his social recovery. For several months following his discharge from here, he worked; then he reënlisted fraudulently in the United States Army, receiving his second S. C. D. From January to October, 1918, he held five different positions, one in a munitions plant at nine dollars a day which he held only three weeks. It was at this time that he came under social-service supervision and during the following year an attempt was made to stabilize him. He kept no position over a month. His best work is done under the stimulus of rather romantic conditions, such as booking shows for theatrical companies, display advertising, and working for sensational newspapers.

Case 2.—Stenographer, about forty years of age. Single. Diagnosis—paraphrenia. This case was first referred in

[1] Surgeon's Certificate of Disability.

September, 1918, by the Liberty Loan Committee, who had been obliged to discharge her because of her difficulties with other employees. She is a small, spare woman with nervous motions, and is quick in taking offense. She has a tendency to be jealous of other employees and to think that she is not fairly treated. She is always straightening out papers and arranging and rearranging things to suit herself. Although she is a first-class stenographer and typist, she seems unable to adjust to any environment. The Y. W. C. A. employment registry has known her from March, 1917, to date—March, 1920—and has secured for her twenty-five positions. In securing these she was sent to seventy-two firms to make application for work. Her longest period at any one position was one month, the shortest period was two days; and whereas an average stenographer of her training and ability should earn about twenty-five dollars a week, she seldom made over fifteen. With succeeding failures, her peculiarities have become more exaggerated until at the present time it is doubtful whether anything remains to be done other than commit her to a state hospital. In a woman of her intelligence, an earlier attempt at an understanding of her personal difficulties would in all probability have made her a happier human being and have saved to society a useful person.

Case 3.—Young man, thirty years old, of Irish-American parents. Diagnosis—paranoid dementia praecox. The family have long been known to the Charity Organization Society in Buffalo, New York, where patient's father owned a livery stable. He was later a saloon-keeper, and eventually ended up as janitor or doorman at the city hall, which position was a reward for long years as a hanger-on to the political machine. Patient was graduated from grammar school at the age of fourteen, after which he went to work in a lawyer's office, having a political career as his aim and Charles F. Murphy as his idol. His father had been a heavy drinker and during the last years of his life developed tabes. He committed suicide as a result, according to his son, of Tammany's going back on him in the matter of his job at the city hall. Patient's mother cut her throat, with fatal result, the day of her husband's funeral.

After his father's death in 1910, patient left Buffalo and

began a life of wandering from one job to the next. He has lived in nearly every large city in the northern states, San Francisco having held him the longest. He remembers his home as one of constant friction between his parents. His mother never sympathized with her husband's party affiliations, or with his Catholic religion, she being a Protestant. He lived on political gossip and the doings of those in high places, and his mental trouble seems to have gradually followed the trend of his father's. All of his difficulties are due to the revengeful hand of Tammany, which has tried to thwart him wherever he goes, because, when they turned on his father, the family threatened to show up the fradulent methods by which the Democrats had done Hearst out of his governorship. Due to the entreaties of the patient's mother and the fact that they would become unpopular in Buffalo, they refrained from telling their secret, though patient states that he has all the information in his possession and some day may be forced to use it. His justification for his vocational failure is that every job is made impossible by the Buffalo political gang, who will eventually smash even such organizations as the Mental Hygiene Committee for trying to help him. He has kept an elaborate work record from 1910 to 1919, showing 123 jobs, the years in which he held them, the city, type of work, name of employer, wages received, length of employment, and whether he was discharged or left voluntarily. Most of these records have been verified, and the statistics that they present are of especial interest in their bearing upon the problem under discussion. The 123 jobs represent 103 different firms and 33 different occupations. His longest period at any one job was eight months, his shortest period one day, with an average of twelve and one-half days spent at each. He worked a total number of 1,545 days for the time covered, or about one day out of every two. He was 80 times discharged, resigned 20 times, and 19 of the positions were at temporary work. His total earnings for the ten years were $3,316.21.

The kinds of work that this patient did, excluding a few odd jobs, can be grouped under three main headings—jobs as laborer, of which there were 30; clerical positions—32; and jobs as a semi-skilled worker where proficiency is obtained

after a few months' experience—33. Satisfactory estimates or studies of the cost of breaking in men are very few. Those that are available have been made by personnel managers and experts connected with certain industries and are more in the nature of roughly assumed estimates than scientific statistical studies. Using a scale[1] that is considered conservative as a basis for computing the cost of the labor turnover for this one individual, his cost of hiring can be estimated at $47.50, cost of training $960, wear and tear $392, reduced production $1,879, and spoiled work $330, or a total of $3,608.50, a sum that exceeds his earnings by about $300. If we estimate the normal earnings of a man of this class at $1,200 a year, then the total wages that he should have received for this time, or $12,000, must be taken into account in calculating his cost to society. The statistics used here do not include the cost of rehiring by the same firm.

Such efficiency methods as have been used in the past take care only of normal individuals, but the so-called normal workers make up only a certain percentage of the labor supply. The psychopathic employee is not sufficiently normal to fit in to efficiency methods nor is he subnormal enough to be committed to an institution. Hence, he is forced into a life of wandering that eventually works to his own detriment and that of society. Receiving no help toward a more successful handling of his difficulties, he repeats his experience with an endless number of positions, to the great cost of productive labor and capital. The case just cited shows clearly the extent of waste in present methods of handling such people. This man earned only $3,316.21 in the past ten years. The rest of the time he has lived upon contributions made by charitably inclined persons who were moved to pity by his hard-luck stories or else by social agencies. When these were not sufficient, he resorted to grafting, panhandling, borrowing, etc. His waste to industry is shown by the fact that his earnings were less than the cost of labor turnover. And his cost to society is much greater than the cost of maintaining him in a state hospital for the entire period.

Such cases as the above are illustrative of the type of psy-

[1]See *The Turnover of Factory Labor.* By Sumner H. Slichter. New York: D. Appleton and Company, 1919, p. 131.

chopathic employee. It is not possible to estimate at present the exact percentage of labor represented by such individuals, but that they constitute an appreciable number is certain. One industrial organization, which is beginning to appreciate the existence of the problem, recently expressed the opinion that they hesitated to open a psychiatric clinic for fear of being swamped.

Since such individuals exist in such large numbers, some plan must be created to make use of them. This can be done only through the education of the public generally, as well as of employers and employment managers specifically, in the understanding of human nature from a psychiatric viewpoint. Such a program must necessarily be slow, since the lack of understanding and prejudice of the public at large are one of the greatest factors in the problem. Society's resistance to an insight into its own make-up leads it to treat as mysterious and dangerous all mental abnormalities. That the correction of society's state of mind is one of the tasks of mental hygiene is evident.

It is not necessary, however, to await the general awakening on the part of the public at large before undertaking more practical measures to deal with the employment problems of the psychopathic worker. There are already in existence a number of excellent courses which train workers in the recognition of mental symptoms—teaching something of their causation—and in the means of assisting such individuals toward social and vocational adjustment. Psychometric tests are of value and mark a decided step in advance, but since they do not take into account the emotional or the personality factors in the situation, they are not a solution of the problem. In order to identify the psychopath in industry and effectively utilize him, each employment department should have on its staff at least one person who has been trained to recognize and handle such individuals, not alone for the purpose of placing him at work, but of securing an adjustment to that work that will insure his maximum of productiveness to industry and of satisfaction to himself. The cost of training one member of the staff of each employment department in mental-hygiene principles is infinitesimal compared to the money wasted in allowing present methods to continue.

The United States Commission of Labor Statistics[1] has said that unemployment, although not yet recognized as an industrial accident, nevertheless causes more slowing down of production, demoralization, and suffering than all other industrial mishaps. Among the various causes of unemployment, he mentions the lack of a properly balanced organization of industry, the lack of an intelligent employment policy for hiring and handling men, the failure to gain the good will of employees, and the failure to make use of the tremendous latent force lying dormant in the workers. Each one of these causes has a special significance to those who earnestly believe that in a scientific inquiry, and in more understanding of the needs and creative possibilities of the psychopathic states in human nature, lies an effective weapon for striking at the roots of the current unrest.

[1]Meeker, Royal. The Cost of Industrial Accidents. *Monthly Labor Review*, Vol. X, pp. 1-13, April, 1920.

MENTAL MECHANISMS*

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PSYCHOANALYSIS is a method by means of which the deeper motives for human conduct and thought, both normal and abnormal, are sought. The application of this method and the things it has disclosed have led to the building up of a certain nomenclature, which I will try to cover in as simple and definite a manner as possible. Some of the terms have been applied somewhat differently by various writers, and there may be some criticisms as to the exact phraseology or meaning as outlined below. No originality is claimed; the sources from which the information has been compiled will be found listed at the end of the paper, and due acknowledgment is gratefully made by the writer to all the authors mentioned.

The mind does not consist of ideas scattered at random; it is quite the opposite. Ideas are grouped about central experiences and built into an harmonious whole. The process has been likened to the way in which brick, stones, etc., are brought together to form buildings, these in turn forming a town or a city. The mental cement that holds these stones and bricks together is feeling or emotion or *affectivity,* a term worthy of a few words of elaboration. One or two examples will illustrate its importance to us in our daily life and mental processes. A prick in my finger causes me to withdraw my hand; if I am frightened by it, I run away; if I am angered, I fight; etc. In the presence of an affect, all opposing associations are inhibited, whereas those in harmony are facilitated. Affects are readily transferred; thus the place where something unpleasant has occurred is hated, or we hate not only the person who has done us an injury, but the innocent bystanders, etc. Affects have the peculiarity of lasting

* Elaborated from a lecture and clinic given at Central Islip, New York, August 3, 1920, to the students of the Summer School of the Eugenics Record Office, Cold Spring Harbor, L. I.

longer than the actual occurrence; for example, a pleasant experience tends to leave an agreeable mood for some time. Whoever has seen something worth striving for which has excited his affects will endeavor to gain it, and duration of effort is in direct relation to the strength of the affect. Affectivity in this way determines perseverance, and efforts may be continued even after the object has been removed. The hindrance to free judgment brought about by affects may be more disadvantageous than useful; for instance, one does many foolish things in anger or in love, etc., while negative affects like fear and anxiety may render us defenseless to danger. Affectivity, far more than reflection, is the determining element in our acts and omissions; on the whole we are always striving for experiences accompanied by agreeable affects and we avoid the opposite as far as possible.

In certain types of individuals occur constellations of ideas that are grouped about or dependent upon an experience that is unethical or antisocial or in some way painful or disagreeable, and the tendency is to crowd such memories from consciousness—i. e., to forget or to *repress* them. Many times these repressed ideas with their accompanying affective states lead a rather detached existence in our unconscious and in so doing give rise to various symptoms. Such a repressed group is called a *complex.* This complex frequently does not remain quiescent in our unconscious, but strives for recognition, for admission to the conscious. This is called the *conflict.* Its admission is prevented by what Freud calls *censorship*—that is, the inhibitions imposed by our social customs or our religious and ethical training. In the psychoses this censorship is to a greater or less extent removed, and the content of the delusions and hallucinations represents more or less clearly the repressed conflicts.

While the censorship may not be able to keep the complex completely buried, it may be powerful enough to prevent its escape in its naked form; i. e., it may appear in *symbols,* disguised, and a symbol tends characteristically to be shorter and more condensed than the idea represented. Symbolic modes of thought are also more primitive and represent a reversion or regression to some simpler and earlier stage of mental development. They are, therefore, most often met with in con-

ditions that favor such reversion—i. e., in fatigue, drowsiness, the neuroses and psychoses, in dreams, etc. Another process is that in which the emotion is transferred from the painful subject to an innocent or less painful one, and this process is called *displacement,* or it may appear as a physical symptom —i. e., *conversion*—or as an entirely different emotion—i. e., *substitution.* These terms are especially used in the description of hysteria, into which disease another mechanism enters; in fact, it is the pivot on which the psychological theory of hysteria rests—i. e., *dissociation.* By this is meant a splitting of the personality so that a system or a constellation of ideas exists independently and is separated from the normal trains of thought by a wall of amnesia. Naturally this dissociation process is not confined to hysteria, but is met with in many other mental states and is intimately associated with what has just been described—i. e., repression and complex. Neither am I to be understood as limiting the use of the terms of displacement, conversion, and substitution to hysteria. These mechanisms, on the contrary, form part of other mechanisms; for example, see dreams, distortion, etc.

Before going on to describe the many other mental mechanisms, let us first discuss what we mean by the *conscious* and the *unconscious.* If I mention the name of an object, such as an orange, you at once have a mental picture of the object, which picture is the end product of many past experiences with that object. You cannot look back and say when you first learned that the orange was yellow or that it had weight or that it was juicy or that it had a certain taste or that it came from certain places, etc., all of which things had to be learned before your mind could form the mental picture that it does at present. The present mental picture represents the conscious; all the past experiences that have gone to make up the picture represent the unconscious, the so-called forgotten, but psychoanalysis tends to show that things are not forgotten; they are only buried, they are not where they can be readily called to mind. And it is only when such forgotten or buried or repressed memories are laden with a painful affect that they become possible sources of harm.

The mechanisms of forgetting or repressing are constantly at work and are frequently seen in our everyday life.

For example, I was with some people at the theater one evening. Directly in front of me was a man whom I had known all my life, but who was on this occasion quite drunk. Throughout the performance his conduct was more or less disorderly, and also throughout the performance I was puzzled by my inability to remember his name. It was not until later that the explanation of this became clear—i. e., under normal conditions I would have introduced him to my friends at the end of the performance. As I could not remember his name, I was saved this embarrassment.

The field of full consciousness is a limited one. The great majority of our mental states, our desires, inclinations, and actions are conditioned by mechanisms of which we are more or less unaware. Freud uses the term conscious to denote all the mental processes of which a person is aware, distinctly or indistinctly, at a given moment. Not sharply marked off from these are the preconscious memories—that is, things which are not at the moment in one's conscious thoughts, but which can be fairly readily and spontaneously recalled. Unconscious memories are those that cannot be spontaneously recalled, but that can be evoked by the use of special methods such as hypnosis, psychoanalysis, etc.

Another very important mental mechanism is *wish fulfilment,* a mechanism very frequently seen in abnormal mental states. It is quite normal for us to wish for things, to elaborate mentally a situation in which such wishes are gratified, even to give way to *phantasy* or *daydreaming.* When wishes are contrary to our present ethical standards, they are frequently *transposed* into their opposite and expressed as a fear. For example, the old maid who looks under the bed for a man really has a concealed wish to find a man; and the much more serious symptom often met with in the mentally deranged, the fear that some one is dead, frequently means that they wish the death of that individual. Such a wish naturally carries with it a strong affect and can be very harmful. Phantasy offers escape from a hateful present, and when such a hateful present or hateful situation confronts us, it is natural to seek an easy solution—i. e., to imagine it as already in effect. Up to a certain point this mechanism is a healthy one, but as soon as it gains such hold on the individual that it re-

places the healthy and normal effort, it begins to do harm. We can all of us look among our acquaintances and see the ones who make good through effort and the others who fail through daydreaming. This tendency to live in a life of phantasy is frequently a carry-over from the period of childhood, for childhood is full of phantasy, children are always playing at being this or that. The type of thinking that leads to phantasy is conditioned by what has been called "the pleasure-pain motive"—the individual shrinks from the necessary effort; whereas if he does not shrink, but acts to accomplish his end, his thinking is conditioned by "the reality motive."

This leads us to speak next of *dream mechanisms*. Dreams, according to Freud, are expressions of wishes, and in dream life the censorship previously mentioned is much reduced in power; hidden complexes or wishes come into their own. But when the dream is repeated on awakening, the censorship serves to interpose certain things that disguise or distort it, so that its so-called manifest content—that which appears on the surface—is quite innocent as compared with its latent content, which, if brought out by analysis, exposes the repressed conflict. The feeling of anxiety or fear or disgust, if it remained attached to that portion of the dream to which it belonged, would disclose to the dreamer the real thing about which he is anxious or fearful or disgusted, but if placed on some indifferent or innocent part of the dream, it serves the purpose of distortion. These additions made to the dream while it is being related are called secondary elaboration, and the disguise is also aided by the mechanism of condensation. A dream is always laconic; it expresses a great deal by a few pictures. And dreams are peculiar in that time is abolished; the events of years may be crowded into minutes, chronological order is disregarded, and a person or an object may represent several different things. Displacement—Freud, I think, limits the use of the term displacement to the movement of affect—also occurs; that is, elements that are of minor importance in the latent content appear prominent in the manifest, and vice versa. Another dream mechanism is dramatization. The story which is the real latent content is not told; it is pictured in the same way as a story is told on

the stage by pantomime or by the movies, and symbolization is freely called on.

Distortion I have just casually mentioned under dreams. It hardly needs further explanation, its meaning being clear in the word itself. Naturally, as above indicated, it is often combined or associated with other mechanisms—i. e., displacement and substitution. In the psychoses a very common substitute is electricity for sexual sensations, and that there is a certain overlapping of terms is shown by the fact that this might be described as a symbol.

Other mechanisms are those of *compensation and overcompensation;* for example, a feeling of guilt because of a sinful act or thought may lead to an individual's becoming very particular about some apparently innocent everyday act, such as those relating to dress or to cleanliness; or he may become overscrupulous or prim or strait-laced or overreligious, etc. The *mechanism of atonement* is another type of compensating mechanism. I do not mean to be understood, however, as saying that compensatory mechanisms are encountered only when there is a wrong to hide. In various mental states we may find numerous instances where the delusions are clearly traceable to an individual's desire to compensate or be compensated for some lack in himself, as a failing efficiency may be replaced by boastfulness, expansive claims, etc. One might say that this approaches what has been described as wish fulfilment, and no doubt this statement is correct. There are no hard-and-fast lines between many mechanisms that are discussed separately in this paper. In normal life we see many admixtures in motives and necessarily so; so in pathological states we see many mechanisms blended and overlapping, and primary mechanisms must necessarily appear in the secondary ones.

The term *projection* is applied to a variety of things. It implies a transferring over to others of what is in ourselves, as in the case of jealousy, which often means that the partner is accused instead of the guilty one, or where the accusations of a guilty conscience are turned into accusing voices that come from others, etc.

Paranoid mechanisms are those that tend to interpret things heard or experienced or imagined, etc. as persecutions. They

are often combined with an underlying wish; i. e., that which forms the opposition to fulfilment of wishes is projected as persecution.

Negativistic mechanisms are those that tend to shut out the external world or to shut off interference—as by mutism, resistiveness, keeping the eyes closed, stupors, etc.—and are an extreme of the defensive mechanism to be next mentioned.

Protective or defensive mechanisms were well shown in the war neuroses, and arose out of the primary instinct of self-preservation. Sets of factors exist in every living organism that work toward the saving of that organism from destruction. Also, for each important function of that organism there exists a mechanism to protect it against hyperfunction and to defend it from injury. The protection may be purely automatic and mechanical, as in hypertrophy of the heart, or it may be chemical, as in immunity reactions or a polyglandular endocrine activity, or psychic, where deep and intricate mental processes are called on. A soldier, on first entering an active zone, tends to feel fear, which may be accompanied by various thoughts, as of running away. However, he soon sublimates this fear into a desire for action—a desire to retaliate on the foe or to aid his comrades, etc.; thus sublimation—which will be discussed later—is here also a defensive mechanism. As time goes on, due to one cause or another, the sublimation may break down and the old fear returns with a desire to get away from it all. Finally the soldier may be buried by a shell explosion, or some other especially terrifying experience may occur, and to defend him against further injury a neurosis develops. This serves the double purpose of removing him from danger and doing it without the brand of cowardice, and naturally is often a very clear wish fulfilment, the entire sequence of events and the underlying motives being quite unconscious or free from volitional control. The defensive mechanism has fulfilled its purpose of protecting the individual against reëxperiencing the series of destructive events to which he has recently been exposed.

War or situations of physical danger are by no means necessary, however, to demonstrate defensive mechanisms, as in the case noted by White of the woman who entertained re-

sentment against her husband. After she was in the hospital, he sent her many things, among them pencils, as she was very fond of writing. As soon as she was given a pencil, however, it would be mislaid or lost; in other words, the pencil was a concrete reminder, it caused a painful emotional state, and she defended herself by losing it. Dream mechanisms are, of course, very typically defensive.

Fixation mechanisms are perhaps best illustrated also in the war neuroses; for example, after a soldier has suffered exhaustion, loss of sleep, hunger, etc., an incident occurs which is associated with an intense degree of emotion, as when he is caught by an exploding shell. This causes a longer or shorter period of unconsciousness, which may also be caused by a psychic shock without any physical injury. During this period of unconsciousness or perhaps only dazedness, there is greatly lessened inhibition and certain symptoms become fixed so that they remain after consciousness returns. These may be mental or physical, an example of the latter being an attitude of fear or of protection or tremors, etc.

The mechanism of justification is, or was, well illustrated by the drinker who drank when it was hot to cool off, when it was cold to warm up, when he was joyous to celebrate, and when he was sad to drown his sorrows; that is, he could not control his habit, so he had to find reasons for indulging it that would justify his conduct to himself. We often see the same thing in the lazy or the indolent, etc.

Regressive mechanisms are those states in which the individual tends to think or act or feel as in an earlier stage of existence, either of himself or of the race; that is, the patient may regress to express himself or to live as if a child, with childish ideas about certain bodily functions, especially those connected with the sexual function. In such a case symbolization is freely called on, with the introduction of various extragenital zones, such as the mouth, the gastro-intestinal canal, etc. The regression may go beyond the infantile stage of the individual to the infancy of the race, with the introduction of myths and mythological characters, fairy tales and folk lore. The further one regresses from reality or the present, the more grave as a rule is the prognosis.

Sublimation is the opposite of regression. To illustrate,

when a young woman disappointed in love betakes herself to a convent, the trend of love has been replaced by religion—i. e., she shows sublimation to religion; or she may get out of her difficulty by a psychosis in which the whole affair is represented by wish-fulfilment mechanisms elaborated along the line of childhood fancy and so show regression to the infantile. As an example of the intermingling or interdependence of terms, we have the often encountered case of the girl or young woman who washes, clothes, fondles, and cares for a doll as it were a baby; that is, she has transferred or displaced the affect properly belonging to baby to doll and also shows regression.

Thought may be substituted for conduct and imagination for reality. This substitution is called introversion as, for example, when a young man courts his lady only by day-dreaming. If he siphons his interest over to a domestic pet, it is still regression, but not introversion, as it deals with something external; and if we carry it a little farther to its causing him to work harder and better, it is sublimation.

We may approach the term sublimation by another path also. Although defense mechanisms may work with great efficiency, they do not always succeed. Some compromise is then sought, some compensation that will enable the person to bear his burden. The character by which we are known is often the result of this sort of solution of inner conflicts. People noted for their wit frequently are persons really sad at heart, and they develop a character that expresses quite the opposite of what they really feel. The inner conflicts, the result of discrepancy between desire and possibility of accomplishment, furnish much of the energy, by a process of sublimation, for our activities. In the weak and the poorly organized, they lead to nervous invalidism or result in psychoses, but in the strong they lead through sublimation to accomplishment, to energy along productive lines, to success in life, to a good social adjustment to one's environment. To compare sublimation directly with regression, as indicated in the beginning of this paragraph, we may quote from Freud's theories. For example, sublimation of the infantile curiosity and exhibitionism gives rise to shame; sublimation of the homosexual infantile component to loathing and morality;

sublimation of the sadistic and masochistic components to pity and similar feelings. In defining sublimation, the very apt word "refined" has been used. "Here may also be mentioned the terms *individualistic* and *altruistic*—i. e. types of thinking or of personality which are definitely related to regression and sublimation, and also to mechanisms mentioned earlier, such as phantasy, wish fulfilment, etc. The egotistical individual who is self-centered, whose thoughts are autistic—i. e., always of himself, his pleasure, his bodily comfort—who is dominated by the pleasure-pain motive, is individualistic, whereas the one who has thoughts for his neighbors, who takes pleasure in seeing others happy, who wishes to advance the world and better his fellow men is altruistic.

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ABSTRACTS

THE PERSONALITY OF THE PATIENT: A NEGLECTED FACTOR IN TREATMENT. By Louis Casamajor, M.A., M.D. *Journal of the American Medical Association,* 75:471-473, August 14, 1920.

The truism that the physician should treat patients rather than diseases has become so much a medical platitude that usually it is not appreciated in its full meaning. To most physicians it means that the therapeutic indications depend more on the individual variations of the patients' reaction to the disease process than on any intrinsic nature of the disease itself. This individual organic reaction is ever an important factor in symptomatology, especially in acute diseases; but besides this there is the individual psychologic reaction to disease, which plays an important part in the symptomatology, prognosis, and treatment of all diseases, but principally those of chronic course. Disease, and more especially chronic disease, is an added experience element in the life of the patient, and one that must be considered in his adjustment to his life, both present and future. Chronic organic disease usually necessitates a change in the patient's mode of life, makes life more complicated and often less pleasant, and thus forces on him an adjustment to lessened activity and interests usually quite at variance with his former life.

Thus, in all diseases of long duration, frequently there comes sooner or later to the attention of the physician a group of symptoms which, although they have nothing to do with the organic groundwork of the trouble, yet may cause more real difficulty to the patient than those more real in nature. Usually these are passed over lightly as "neurotic symptoms," and the patient is left to suffer more in mind than he does in body. This is a mistake, for these are the symptoms that can be removed, greatly to the comfort of the patient, a process all too frequently done by the "faith healer" or other quack, all to the detriment of the physician. The physician who understands and treats the patient should be the one to understand and remove these symptoms; and only when he does this does the physician justify the ideals which the community holds for him.

My purpose is to point out the origin and nature of these added symptoms appearing in chronic organic diseases, and their importance and significance to the patient. Probably it is better to term them "personality symptoms" rather than simply to name them "neurotic symptoms," for by such a term we are likely to remove them

too far from their real connections with desease. They are "patient symptoms" in contradistinction to "disease symptoms," and they represent the psychologic readjustment of the patient to his environment, now further complicated by his disease and his realization of his lessened efficiency, which the true disease symptoms have forced on him. A case in point may not be out of place:

B. D., aged 43, a waiter, came to the Vanderbilt Clinic complaining of insomnia, nervousness, tremulousness, excitability when subjected to sudden noises, and pain and hot feelings in the back of his legs and thighs. Formerly he had had a business of his own, but two years previously he failed and had been obliged to accept a position as a waiter in order to support himself and his family. He had never been content with this adjustment and, with the mounting cost of living, his life had become more difficult. About one year before, the nervous symptoms mentioned began to appear, and they had gradually become worse. For the last thirteen years his vision had been failing, especially his ability to see clearly in the dark or in very bright light. At that time he was told in an eye clinic that he had "night blindness." This condition had progressed but slightly, for his vision now was 20/50. About five weeks before coming to see us he was struck in the leg by a motor truck. He was laid up at home with pain in his leg for a few days, but soon was again obliged to take up his work to support his family. At this time the pains and hot feelings in his thighs and legs appeared, and were present only during the day while he was at work. Physical examination was entirely negative except for some narrowing of the visual fields, and a retinitis pigmentosa of moderate degree.

Most interesting in this case is the fact that the patient voluntarily came to a neurologic clinic with a history of symptoms quite "neurotic." Only on extended questioning was one able to bring out symptoms of the organic disease from which he was suffering. To his mind the psychic symptoms were the more important, for they occupied his thoughts much more than did his vision difficulty, and interfered much more with his efficiency as a worker. These were the "personality symptoms" in this case, and represented the reaction of the patient to his life, now made further unpleasant by the presence of the organic disease whose results he feared.

The meaning of the "personality symptoms" is clear. Excitability to noises, tremulousness, and anxiety are all symptoms of fear; and fear was the predominant psychologic element that his organic disease had injected into his life. He had been told he would never get well and in all probability would eventually lose his sight. This prognosis and the fear it engendered altered the whole course of his life. An-

other individual of different personality, possibly more philosophical, might have accepted the condition as it was and not have developed such active fear, and so not have altered his attitude toward life. However, our patient was of different fiber, and complicated his unhappy lot by the addition of a group of fear symptoms of his own making.

He began to take more interest in himself than in his business and, following his business trouble, he accepted the position of waiter because he lacked ambition to build up his own work again, and the position of waiter was an easy compromise in the difficulty in which he found himself. It was not satisfactory, for he felt that his earning capacity had been permanently diminished by factors over which he had no control—namely, the organic disease. This disappointment, then, gave rise to the depression with the anxious coloring which dominated the clinical picture when he came to us, which was manifested by the "neurotic symptoms." These are the symptoms that are capable of removal, while those of his retinitis are not. To remove these symptoms would be to increase his happiness and raise the level of his efficiency as an earner, probably to very nearly his former level. This neurotic part, then, all too frequently neglected, should be the part to receive the greatest attention of the physician, for it is with this part that the best therapeutic results are possible.

This patient reacted psychologically in this way to retinitis pigmentosa. It is most probable that he would have reacted in quite the same way to any other chronic organic disease that impaired his efficiency and darkened his future. In this man we would have expected to see the same symptoms had his organic disease been chronic nephritis, diabetes, chronic arthritis, chronic cardiac disease, or arteriosclerosis.

These neurotic or personality symptoms we see appearing in many patients with chronic disease, and in every case they depend on the personality of the patient and his psychologic reaction to his disease, and not primarily on the disease itself. Not all individuals suffering from these chronic diseases complain of the same neurotic symptoms, and many never develop such symptoms at all or allow their disease materially to alter their attitude toward life. This difference depends on the individual psychologic differences between patients—that thing we call personality.

When one comes to analyze the foundation of these "personality symptoms," a number of factors readily come into view. Probably the most important of these is the element of "temperament" of the individual. Often it is extremely difficult to determine on what this is based. We know one person to be optimistic and another pessi-

mistic in his general outlook on life; one is naturally euphoric and another easily depressed; one is care-free and another full of worries; one is good-natured and another irritable and quick to anger; one altruistic, another primarily selfish. An attempt to analyze such characteristics takes one deep into the field of psychology; yet a few of the most prominent factors may be mentioned.

Age plays an important part. Youth is hopeful; old age is sad. The attitude toward chronic disease frequently reflects this age element. The hopeful attitude of the tuberculous, especially those of early adult life, is proverbial, and most likely depends more on the age of the patient than on anything in the disease itself. The carcinomas, on the other hand, are usually seen in later life, and here again the hopeless depression is, in part at least, a symptom of the age of the patient. Besides this there are many other factors which determine temperament; the racial traits in the patient, the history of his life's experience, the hardships he has undergone, and lastly that thing which we call "feeling of well-being," in which we find many elements, but especially the proper working of his bodily organs, in the disturbances of which his disease itself may play no inconsiderable part.

Given, then, the individual of a certain temperament afflicted with a chronic, but not disabling, disease, we may see extra personality symptoms arising in the clinical picture according to the patient's needs; and often these symptoms completely obscure those of the original disease. Two questions naturally come to mind: Why does the patient need these extra symptoms, and where does he get them?

The need for the extra symptoms springs from the patient's need to express the feelings that his disease engenders in him, in terms more understandable to himself and others. In the first place, the realization that he is diseased brings with it a feeling of personal insufficiency and inadequacy to meet the requirements of his existence. Often he now begins to care for his health for the first time in his life, and this introspection leads to an introversion of interests so that he may give consideration for his health an excessive relative value over the other factors of his life. We then say that he has become "hypochondriacal." He seeks for symptoms in himself; and when he seeks he finds, often in the exaggeration and perpetuation of temporary symptoms formerly unheeded.

Another factor not to be too lightly valued is the striving for sympathy, a real need to the sick human being. While we sympathize with chronic disease as a theoretical proposition, yet in the concrete we sympathize only with symptoms. Hence the need of these extra symptoms to get for the patient the sympathy and consideration he

feels is but his just due. If his disease has few outward manifestations to call for sympathy, he can, if he needs, develop others, in the form of pains, weakness, and anxieties, all of which impress the beholder.

The source from which these extra symptoms are derived is suggestibility, that all-important element in human psychology. Suggestibility is the ability to accept with conviction a communicated proposition in the absence of logically adequate grounds for its acceptance. It is the basis for faith and belief, and the human mind believes always just what it wants to believe. This increased suggestibility of the chronically diseased may depend on one or both of two factors: (1) an abnormal state of the brain caused by the disease process, or (2) a deficiency of knowledge of the nature of the disease and what symptoms it may cause.

To the hyper-suggestible patient who needs extra symptoms, suggestion for the formation of new symptoms comes from many sources and in varied forms. From his own past experience with disease and neurosis he may cull much that meets his needs. The conversation of kind and sympathetic friends is usually a rich field for suggestion. The reading of medical books and articles and "patent medicine" circulars will provide any number of useful symptoms. And the suggestion all too frequently comes from the physician, often from an unfortunate chance remark or even from the expression of the face during an examination. It was frequently said in the British army in the war that many soldiers got "soldier's heart" from a medical board.

These extra symptoms in organic disease should receive the most careful attention from physicians. Often they are more disabling than the disease itself. Anyway they are more susceptible of removal, and by their removal the patient's happiness and efficiency are improved. In the technic of removal one must counteract the factors that have caused them. The temperament of the patient is often susceptible of improvement by a better understanding of himself and his motives. The need for the extra symptoms is often still more difficult to combat. This need may be lessened, in the first place, by a more accurate knowledge of the nature of his disease and its process. Then again, the patient's adjustment to his disease and his lessened efficiency may be made more compatible with mental health and happiness. Many physicians do this by telling of other patients with the same disease who had made better adjustments, and by giving the details of how it was done. And, lastly, symptoms due to suggestion may be removed by contra-suggestion. Suggestion has ever been a considerable part of the armamentarium of the successful

physician, suggestion by word, by act, and by attitude, as well as suggestion connected with physical and chemical therapeutic practices; and this healing suggestion should be applied to the organically ill quite as much as to the pure neurotic.

Psychiarty and Internal Medicine. By C. F. Martin, M.D. *Canadian Journal of Mental Hygiene*, 2:137-143, July, 1920.

In this paper, which was read before the Ontario Medical Association, Dr. Martin, professor of medicine at McGill University, discusses the relation of psychiatry—using this term in the sense of the newer and more inclusive title "neuropsychiatry"—to many of the problems encountered in the practice of internal medicine, and urges the importance of more adequate psychiatric training for physicians than is at present provided in medical schools. The paper reads in part as follows:

"One is apt to talk rather glibly about a patient having 'lost his reason,' having 'lost his senses,' when as a matter of fact the mental disturbance may in no way have affected the intellect or the reason, while the changed emotions alone may be responsible. The patient has merely 'lost his table of values,' and is much like a child who cannot adapt himself to his environment, and the inner harmony is lacking.

"It is in just such conditions as these that the physician, be he a general practitioner or be he skilled in the refinements of physical diagnosis, is apt to fall short.

"No inconsiderable training is required before one's opinion becomes of value.

"Etiologically and symptomatically, the behavior of the sane and insane is largely one of degree; certainly this is the case with neurasthenics. The chief difference between them is in the mental conflict which requires careful analysis and consideration. The general practitioner is called upon to decide between the sane and the insane, to diagnose exactly, if he can, between the various types of psychoneurosis, between the different types of personality, if you will, and to advise as to disposal. To commit or not to commit—that is the question, and the decision is ofttimes an urgent one. He is called upon to decide as best he can between the emotional and the intellectual, to deal with disorders of human adjustment, and with distorted methods of meeting the complex situations of life, all of which are problems the solution of which requires specialized training.

"He must be skilled in questions of mental hygiene, of adaptability to environment, and the reactions that arise therefrom, and no one untrained in psychology should presume to offer a final opinion.

"It is obvious that the general practitioner is called upon to decide something in which his previous training has been defective. He has not learned to appreciate the degrees of personality; in fact, he probably does not presuppose a personality in most of the patients that come within his ken. . . .

"Unless the physician can appreciate that human conduct is dependent upon certain fundamental reactions, unless he can understand the patient in all these relations, his task of disposal and treatment is a difficult one. Consider the immense multitude of people outside of institutions who would be the better for such care. Consider the numbers under supervision or parole—recall, in fact, the myriads of border-land types in every country—and we can gauge the magnitude of the physician's task in diagnosis and disposal.

"It is just in these very matters that the physician is apt to fall far short of the ideal, to lose patience, to become apathetic, indifferent, or critical. It is a lamentable, but well-established fact that many of these psychoneurotics, as a result of maladaptation or what not, commit offenses of a major or minor importance, and are regarded merely as infractors of the law and not as psychopaths.

"The jails and reformatories are filled with people of this kind, who should long ago have come under the skilled attention of the psychiatrist.

"The general practitioner, as a rule, is more or less in despair over mental cases unless the type he be confronted with is an outspoken one of mania, dementia, or melancholia.

"One can well picture the helplessness of the average physician who is consulted about a feebleminded child as to disposal or treatment, or any other information.

"Indeed, I fear it is a rare thing for a physician to take sufficient time with a psychopathic patient to get more than merely the broadest outlines of his trouble.

"It is a wearisome matter for physicians—these tales of worry and grief and failure—and the patient is more apt than not to be told to forget his worries, to take a holiday, or to go to work, the physician forgetting that work should be the sequel, but not the substitute for the doctor's own labors.

"Not alone is this the case with psychopathic cases, but in all organic nervous disorders the physician overlooks to a surprising degree the functional element. . . .

"Wherein lies the difficulty, and what is the result?

"The causes are many. First and foremost, we must depart from ancient traditions and prejudices. We must learn to look on patients with mental disturbances as something apart from madhouse inmates. We should be done with the era of straw and chains, and

patients with all forms of mental disease should be as carefully and considerately observed, treated, and relieved as those with any disease of the lungs, or heart, or digestive tract.

"In almost every medical school in Anglo-Saxon countries, psychiatry is dealt with as a minor subject. The course consists of a few didactic lectures; a few, very few, visits to a lunatic asylum, where the demonstrations are apt to be more a theatrical than an educational sight. Chiefly, the rare, well-advanced types of mental disease are exhibited, veritable caricatures of mentality.

"The teaching of psychiatry has well been compared to a course of instruction in navigation carried on by the inspection of a few wrecks, or to a training in engineering through the exhibition of a few broken-down dynamos—and all this, too, in spite of the fact that there are in public institutions more insane patients than of all other diseases put together.

"Border-line cases, on the other hand, unusual personalities, cases on parole, can neither be stressed nor discussed, for *ipso facto* they do not exist in asylums, when no case can enter an asylum that is not legally committed. The result is that instruction in our schools is necessarily limited, and few students have opportunities to study the most important feature of psychiatry—viz., the border-line cases.

"We must treat cases early, and treat early cases; must recognize the importance of treatment out of asylums, of forming pavilions or departments in general hospitals, where till now such cases have always been unwelcome guests.

"We must educate the public away from fear and prejudice, and cast off the stigma that attaches so wrongfully to these types of disease. Prevention is still better, by medical clinics in the courts, by education, and by the organization of adequate social service.

"Moreover, there is urgent need of an adequate course on psychology in its application to medicine and psychiatry. It must be made a living subject, and in order that it may be duly appreciated, its study should follow upon the instruction in anatomy and physiology.

"These two latter subjects should be (and I am glad to say now usually are) dealt with in a much more practical manner, the former emphasizing the relation of functions to structure, while in physiology mental processes are being more and more emphasized.

"Personality in all its relations to abnormal and normal conditions must be an important consideration in every general clinic.

"It may be claimed that the study of personality is an easy matter. Nevertheless, let a doctor be ever so talented, he cannot by personality, by natural insight and understanding alone, deal with mental disorders, any more than he can decide by his personality as to

hepatic or renal or cardiac insufficiency. One must be taught to study the reaction of disease, and too much stress cannot be laid on the importance of the functional element in all organic lesions.

"Let us see to it that not only are students and physicians given all opportunity to learn more of mental diseases, but let us, by every propaganda at our disposal, educate the public to appreciate the greatest hygienic and economic problems in state medicine.

"Thus, and thus only, can our country be saved from waste of energy and capital, and from an incubus of misery and inefficiency that is to-day appalling.

"Light is happily coming, and through the efforts chiefly of the patient, persistent, and patriotic physicians of your own city [Toronto], psychopathic establishments are growing, and with the coöperation of all members of the profession and state, we may be justified in some optimism."

MENTAL HYGIENE SURVEY OF THE PROVINCE OF BRITISH COLUMBIA. Conducted by the Canadian National Committee for Mental Hygiene. *Canadian Journal of Mental Hygiene,* 2:1-59, April, 1920.

In 1919, at the request of the Honorable Dr. J. D. MacLean, Provincial Secretary of British Columbia, the Canadian National Committee for Mental Hygiene undertook a survey of that province. A thorough investigation was made of conditions with regard to the mentally diseased and the mentally defective, the institutions visited including hospitals for mental disease, public schools, industrial schools, orphanages, jails, and mission homes. Each of the institutions studied is discussed in detail in this report.[1]

The chief hospitals for mental disease in the province are those at New Westminster and at Essondale, which are practically under one management. Nearly all the cases of mental disease admitted to a hospital are received at New Westminster, while Essondale has the care of chronic cases (males) transferred from New Westminster. Both these institutions were found to have many admirable features. The report commends the enthusiasm and scientific zeal of the staffs and the absence of mechanical restraint. Favorable mention is also made of the pathological laboratory and the training school for psychiatric nurses at New Westminster and the excellent records there. The report points out, however, that the hospital is overcrowded; that

1 A footnote to the report states that a number of the recommendations contained in it were immediately put into effect. Arrangements have been made for a training school for mental defectives on the Essondale property, for the erection of a nurses' residence at New Westminster, for a new building at Essondale for acute cases of mental disease, etc.

the staff is too small—three physicians in charge of six hundred patients; that women nurses are not employed in the male wards; and that adequate provision is not made for occupational therapy. The housing of nurses in suitable houses is also discussed.

The necessity for a change in the form of admission to mental hospitals in the province is emphasized. A law permitting voluntary admission is urged, as is also committment " on the certificates of two properly qualified physicians, after the superintendent of a hospital for the insane has made an examination of a preliminary form of history to be filled in by the physician in attendance."

Provision for the immediate care of mentally diseased persons, " without the hamperings of red tape and routine," is another reform that is vitally needed in British Columbia. The report advocates the establishment of a psychopathic hospital in connection with the Vancouver General Hospital, summarizing its arguments as follows:

"(A) Such a hospital is an integral part of a complete provincial hospital system, and without it the system goes lame.

"(B) Such a hospital will help check the present rapid increase in the number of the insane by heading off the stream at its source.

"(C) Such a hospital, by preventing and curing cases of mental disease in incipient and early stages, will prevent their becoming chronic insane patients, and will save the state the expense of continuous care of chronic cases for a long term of years in regular provincial hospitals.

"(D) This hospital, by receiving and caring for recent and acute cases of insanity, will diminish the number annually committed to the other provincial hospitals, and so relieve the overcrowding in these hospitals."

Other measures recommended are the establishment of a convalescent home in connection with the mental hospital either at New Westminster or at Essondale; the erection of a building for the treatment of acute cases at Essondale; the employment of one or two psychiatric social workers in connection with the mental hospitals of the province, thus making possible the placing of an increased number of patients on parole; and the establishment of a traveling psychiatric clinic at New Westminster. A recent report submitted to the Hospital Development Commission of New York State is quoted as to the beneficial effects of such a clinic on the hospital, the hospital physician, and the community:

"On the Hospital.

"1. They provide a means whereby the hospital can supply medical supervision to its patients even when they live at a distance.

"2. They provide an inconspicuous place to which sensitive patients are willing to come when they would hesitate to return to the hospital.

"3. By giving parole patients an opportunity to see regularly and frequently a physician who understands them, the hospital is able to keep patients on parole who would otherwise have to return.

"4. They furnish the hospital with its best weapon for combating prejudice and superstition in the district.

"5. They are the greatest means the hospital has for carrying on educational and preventive work; the only method of decreasing the number of commitments.

"On the Hospital Physician.

"1. They furnish a new and stimulating field of work for the hospital physician.

"2. In so far as they undertake to do preventive work, they bring the hospital physician in contact with the beginning stages of mental disease and with the milder forms which rarely reach the hospital.

"3. They bring the physician face to face with the concrete social problems which have to be solved in connection with the mentally ill.

"4. They make the physician realize the importance of the hospital as a social force.

"5. They make the physician realize the importance of the hospital as a preventive medical agency.

"On the Community.

"1. They are of direct value to every social agency in the community, since every such agency has problems involving mental conditions.

"2. They are the means of bringing the community into friendly relationship with the hospital which thus definitely gives its services to aid the community in its mental-health problem.

"3. In cities, they make the psychiatrist accessible to the middle-class citizen who cannot afford to consult the high-priced specialist and in consequence goes without advice or treatment for mental disease or resorts to quacks.

"4. In the country districts, they constitute as a rule the first and only source of diagnosis and treatment of mental conditions.

"5. They provide the most promising instrument for removing popular prejudice against the state hospitals and for raising the general level of intelligence in the state with regard to mental disease.

"6. They give to the community its first real opportunity to organize preventive mental-health work."

The survey of the public schools was conducted with a view to gathering information on the following points:

1. The proportion of mentally abnormal children in the school population.

2. The present facilities for diagnosis and special training.

3. The improvements needed.

A routine examination was made of 2,273 children, and care was taken to select schools that would be fairly representative of the entire provincial system. The children examined came from all the walks of life, their parents being laborers, artisans, tradespeople, and professional and business people. Eighty-one of these 2,273 children—or 3.56 per cent—were found to be mentally abnormal, the highest percentage of abnormality—5.58 per cent—occurring in a school where pupils came from very poor homes.

A good beginning in the way of providing for the diagnosis and training of mental defectives had been made in Vancouver and Victoria. In both cities one or more special classes for mentally abnormal children had been established. In Vancouver the pupils of these classes are selected by the school psychologist, who makes a preliminary examination in the schools and has prospective special-class subjects report for a week at an observation class, where a careful study is made of each child to determine his specific abilities and defects. The results of this study are then given in a detailed report to his special-class teacher, who is thus able to begin constructive work at once. In Victoria the teacher of the special class, who has had psychological training, visits the public schools twice a year and gives mental examinations to children who are referred to her by principals, teachers, and nurses.

The report recommends the extension of the special-class system both in Vancouver and Victoria and in the other cities and the outlying districts of the province. There should be such a class in any community in which from twelve to fifteen abnormals are registered.

A trade school in Vancouver for the older boys and girls is another need. "It is well known that many adult feebleminded are now in need of institutional care largely because of the lack of early vocational training. The expenditures connected with a trade school will therefore save the city and the province much money in the end, and will make possible the social liberty of many who otherwise might need custodial care."

It is also recommended that the services of a psychiatrist be secured to complement the work of the psychologists in the diagnosing of mental abnormality. While highly commending the work of the psychologists, the report adds: "Experience has taught, however, that there are in attendance at public schools a considerable number of children who suffer from beginning mental disease, many children with character defects other than those of intellectual retardation, many neurotic, high-strung, peculiar children, and other types that require for their understanding psychiatric experience (experience in all forms of mental disorders).

"It is of fundamental importance that all abnormal children be diagnosed and properly treated during their school days. Up to the present the retarded and the defective have received special attention, but if we hope to cut down the high rate of insanity in the community, our efforts must embrace a regard for those children who may in later years develop mental disease. As has been said, a mental specialist is needed for this special task.

"It is therefore recommended that the part-time services of a psychiatrist be secured by the board of school trustees. This appointment would in no way curtail the duties of the psychologist, who would still employ psychometric tests. In Toronto excellent results are achieved through the coöperation of psychologists and psychiatrists in the study of cases.

"In another part of the report a recommendation is made for the establishment of a psychopathic hospital in Vancouver. The director of that hospital might, in addition to other duties, give part time to school work."

"All the schools of the province should be visited from time to time by a psychiatrist for the purpose of conducting mental examination of those children who are either pronouncedly backward or peculiar. It is recommended elsewhere in this report that an itinerant psychiatric clinic be established in connection with the New Westminster Mental Hospital, and this organization might then be available for school work. At the outset it would be a large undertaking to investigate the mental status of every school child, although such a procedure is eminently desirable. The itinerant clinic could, however, make a most useful beginning by giving consideration to pronounced cases."

The appointment of a social worker is another measure recommended:

"A social worker with mental-hygiene training would be of great assistance to the special-class system. Such an appointee could with advantage make home investigations, and the information gathered would be helpful in the making of diagnoses and in securing the coöperation of parents and guardians as well.

"It should be ever kept in mind that the function of the special classes consists not only in training, but in observation. A certain proportion of the pupils will eventually prove to be institution cases and their final disposal will depend upon a consideration of characteristics noted in school and, what is quite as important, noted in the home. The careful observation of children outside of school would, as has been stated, come within the scope of the social worker's duties.

"Experience has taught that the particular type of home investigation required for this special work cannot be done satisfactorily by a school nurse unless she has had a training in social psychiatry (mental hygiene). The elucidation of a family history, for instance, with the aim of discovering the truth concerning mental and nervous characteristics of the family involved is highly specialized work and requires not only tact, but wide psychiatric experience."

British Columbia had at the time of the survey no training school for mental defectives. The urgent need for such a school was shown not only by the public-school findings, but by the results of surveys conducted among juvenile delinquents, occupants of orphanages and jails, and sexually delinquent women.

The investigation in connection with juvenile delinquency included the following organizations: the Vancouver Juvenile Court and Detention Home, the Provincial Industrial School for Boys (Vancouver), and the Girls' Industrial School (Vancouver). Mental examinations were given to 155 juvenile delinquents, and of these 91—58.7 per cent—were found to be mentally abnormal, the great majority of them feebleminded. Of the 19 examined at the Detention Home and Juvenile Court 16, or 84.21 per cent, were abnormal; of the 88 examined at the Provincial Industrial School for Boys, 40, or 45.45 per cent; and of the 48 examined at the Girls' Industrial School, 35, or 72.91 per cent. For these mentally abnormal children, neither the parole system nor the industrial school is an effective reformatory agency. Such children constitute the chief problem in connection with juvenile delinquency, and the only solution of the problem lies in the provision of specialized facilities for their training and supervision. Moreover the establishment of such facilities should be accompanied by legislative action enabling institutional authorities to retain defective delinquents indefinitely.

Two orphanages were visited—the Home of the Children's Aid Society, Vancouver, and the British Columbia Protestant Orphanage, Victoria. There were at the time of the survey 125 children in the former institution. Three of these children were imbeciles. Out of 17 others referred for examination by the assistant matron—because of backwardness in school work and inability to cope with the tasks meted out to the other children—15 were of the mentally defective type and in need of specialized training and custodial care. "A general survey was made of the other children, and it was quite evident that a fairly large proportion were mentally defective. An estimate of 25 per cent defective is probably well within the truth."

Of the 68 children in the Protestant Orphanage, 9 were referred for examination. Four of these 9 were found to be mentally deficient —2 being low-grade imbeciles—and 4 backward.

"It was evident that both organizations could do better work if all their charges were given a psychiatric examination and if the abnormals were transferred to specialized institutions."

A mental examination of a number of the 152 male inhabitants of the Oakalla Jail showed that the usual high percentage (about 50 per cent) were mentally abnormal. "This fact in itself," the report points out, "is conclusive that the proper treatment of the prisoners is not being followed, if reformation, rather than punishment alone, is the goal aimed at. It is self-evident that the mixing of all classes, normal and abnormal, is not the way to develop a system that will discourage the development of the recidivists, restore the normals to confidence and decency, and remove the abnormals from society, where they are a menace both to themselves and the community.

"A brief study of the fifteen women serving sentences confirmed this opinion. We found that eleven were mentally deficient, two were of inferior intelligence, and two probably normal. Of the fifteen, ten acknowledged that they were prostitutes, and nine users of drugs. Surely facts such as these warrant the most earnest scrutiny when the question of the ultimate disposition of the group is considered, and yet Oakalla has nothing to offer in the way of a solution of the problem. It seems absurd to argue that the thirteen defective women should be liberated at the expiration of their sentences, only to return to society, where they have already demonstrated their inability to do otherwise than to act as vultures and distributors of contagion. It is not an intelligent way of dealing with the question. To illustrate the inability of these women to rise superior to their mental hamperings, it may be said they evidenced little or no conception of moral worth, and showed a callousness that would appear unbelievable to people not accustomed to dealing with these classes. Never before have we met with types more hardened than these. They not only discussed their prostitution, but showed no evidence of shame and boasted of the number of men with whom they had immoral relations daily (in some cases 30 to 40). The most degenerate had been living in the Chinese quarters in Vancouver. The prevalence of the drug habit, too, was impressive, and evidently played an important part in submerging the defectives to the lowest depths of vice; indeed, we have nowhere seen demonstrated so clearly the intimate relation existing between the drug habit, defect, and delinquency. Many of these defective and dissolute women were recent arrivals from the United States, and no doubt came to Canada to escape from the severe drug laws in force in the United States."

To determine the relationship between prostitution, illegitimacy, and mental abnormality, studies were made at the Vancouver Jail, the Oakalla Jail, the Central Mission and the Salvation Army Home

in Vancouver, and the Presbyterian Home and the Provincial W. C. T. U. Home in Victoria. The jail findings have already been referred to.

"In the other institutions visited, 29 cases were examined—women who had either given birth to illegitimate children or who admitted sexual immoral relations—and it was found that 28 were mentally abnormal. It is not possible to make any sweeping generalizations from this limited study, because of the comparatively few cases investigated. The findings indicate, however, that mental abnormality and immorality are closely related."

The foregoing facts demonstrate the province's need of an institution in which mental defectives can receive prolonged care and training. It is advised that a school on the farm-colony plan be established on the government property at Essondale, which is amply large enough to accommodate such an institution in addition to the mental hospital already there.

"The type of training school suggested should be constructed along the lines of the institution at Waverley, Massachusetts. At Waverley provision is made for the segregation of defectives according to sex, intellectual development, and behavior. An attempt is made to train all cases to the limit of their capacity. The higher grades are educated in public-school subjects, and boys are given industrial training in agriculture, carpentering, boot making, weaving, while the girls receive special instruction in the household arts."

The burden that is being imposed upon the province as a result of poorly supervised immigration is revealed in the survey's findings with regard to the proportion of foreign-born among the population of hospitals for mental disease and jails.

"Among the insane it is found that while Canadians should, theoretically, supply 43.14 per cent of the admissions to the hospitals for the insane, yet they only furnish 27.28 per cent. In other words, the foreign born constitute 72.72 per cent of the admissions, a showing that is quite out of proportion to that expected. . . .

"The figures for jail cases are even more convincing. An analysis of the records of 3,863 cases shows that only 21.53 per cent are Canadian born, while 78.47 per cent are foreign born."

The report concludes with the recommendation that a mental-hygiene commission be appointed in British Columbia.

"The function of such a commission would consist in making a careful study of the problem of mental abnormality in the province, and of developing a suitable plan for its solution. It should have as its head a well-trained and competent man of high character, in whom the people have confidence, and associated with him should be a well-trained psychiatrist. The latter might with advantage be the

general superintendent of the mental hospitals of the province. A third member of the commission might well be chosen from the legal profession, as so many points of law keep coming up from time to time in connection with all institutions. In addition, there should of course be a secretary.

"This commission should be an independent body, free from political control, but in the confidence of the government and responsible to it. It should be empowered to inspect the activities of all institutions supported by governmental aid."

Social Work and Neurosyphilis. By Maida Herman Solomon. *Social Hygiene*, 6:93-104, January, 1920.

The chief of social work at the Massachusetts Psychiatric Institute discusses here the part that the social worker has to play in the treatment of neurosyphilitics and their families. While the neurosyphilitic has gone a long way from his original infection, his symptoms appearing as a rule from five to thirty years after the original lesion, he is still in need of treatment; and his family, though no longer in danger of infection from open lesions, are likely to have been infected in the past and to show cases either of congenital or acquired syphilis. The social worker, therefore, has to arrange not only for the treatment of the patient himself, but for an examination of his family and the treatment of any cases found there.

"In dealing with the patient, the doctor makes the necessary tests and examinations, decides whether further tests are necessary, whether treatment is worth while, and where it shall be given. The social worker sees to it that all the doctor's recommendations as to examinations, treatment, and home care are carried out. She confers with the doctors on any medico-social problems, talks over social difficulties with patients regularly at the medical clinics, and sees that the social problems are adjusted.

"Again in the family work the doctor and social worker must coöperate. The social worker deals with three groups—the married, the unmarried youth, and the unmarried adult. In group one, when the original patient is married, the spouse and children are examined. In group two it is suspected that the patient may be a congenital syphilitic; the parents and all other children under eighteen are therefore examined. With group three, the unmarried adult, the social work is relatively simple. Assuming that the syphilis was acquired in adult life, no family examination is entailed and all that is necessary is to see that the patient himself is adequately cared for.

"In dealing with the first two groups, considerable social effort is involved in persuading the families to report to the hospital, where

they are turned over to the physician, the psychologist, and the outpatient historian. An examination is made; a family history is taken for adults—with reference to possible infection, history of pregnancies, occupation, income, and status of spouse; and one for children—with regard to development, diseases, education work, recreation, and character. Often one examination is not sufficient for diagnosis and the worker arranges to have the relatives return for repeated or periodical examinations. If syphilis is found, arrangements are made for treatment. . . .

"It must be remembered that while the examination is medical in character, its results cannot be conserved without the aid of the social worker. Experience has shown that a high percentage of success is secured only by the persistent follow-up and persuasion of the social worker. Without such a follow-up many families ignore the appeal to report to the hospital. It is obvious that the physician cannot handle this part of the work."

To prove the necessity for the examination of the families of syphilitics and neurosyphilitics, figures are cited from a recent comparative study of 160 families of neurosyphilitics (general paretics) and 72 families of syphilitics (non-paretics). Of the 226 individuals examined in the first group of families, 23 per cent were found to have a positive Wassermann, and of the 91 individuals in the second group 35 per cent gave a positive reaction. The rate for syphilis infection in the population at large is given as from 5 to 15 per cent, and the rate among yearly admissions to the Psychopathic Department of the Boston State Hospital is from 12 to 14 per cent. "It is apparent that the rate of 23 per cent occurring in the families of neurosyphilitics is considerably higher than is found in any random series of cases." Figures are also given to show the deteriorating effects of syphilis upon family stocks, as evidenced in sterility, abortions, miscarriages, still births, and early deaths.

Taking up some of the problems connected with the work of a neurosyphilitic clinic, the author discusses first the question of financing the treatment, which must continue over a long period of time if it is to be of any avail. Massachusetts has solved this problem by providing for free treatment as well as for free diagnosis and at present is "supplying all authorized clinics with free arsphenamine, not only for infectious cases, but also for chronic forms, including neurosyphilis." It is the author's hope that all the state governments will in time adopt this plan.

The economic aspects of syphilis and neurosyphilis present another serious problem. "The care of cases of neurosyphilis in insane hospitals reaches high figures and means a large tax on the com-

munity. Congential syphilitics fill our feebleminded, deaf, dumb, and blind institutions, and are a considerable problem in children's hospitals. Victims of locomotor ataxia become industrially incapacitated, and many are cared for in state farms and hospitals. . . . A neurosyphilitic may become industrially disabled so that he falls below his former earning ability, and may be permanently incapacitated. He may become a burden upon the home so that the wife and older children must go to work or receive charitable aid. If he is committed to an institution, the home is no longer the basis of family life, but is apt to be broken up, and the children placed out or adopted.

"The possible remedies are medical and social. More efficient early treatment of syphilitics will lessen the number of neurosyphilitics. Prompt treatment of neurosyphilitics will put off the time of incapacity and institutional care. But, even so, the results of late treatment are not perfect, and the patient rarely reaches his former industrial level. The social worker can do much to encourage the patient over a long period of treatment by finding out just what industrial qualifications he has and securing a job which will aid him to retain his self-respect and help support his family. In early syphilis, the man is not incapacitated and the family unit is retained. As has already been pointed out, in neurosyphilis the family is apt to be broken up and the wife forced to earn her living. The social worker can help make these new conditions easier by encouragement and plans for readjustment."

Other important questions have to do with the amount of information to be given the patient or his relatives. Shall he or they be told the exact nature of his disease? If so, who shall give the information, the doctor or the social worker? In the author's opinion, if the patient is fairly competent mentally, it is essential that he be told just what is the matter with him. Otherwise it is almost impossible to gain his coöperation for the long and irksome course of treatment he must undergo. The same argument holds with regard to explaining the situation to the relatives of a patient whose own mind is not clear enough to grasp it. Also, in cases where it is difficult to persuade a patient's family to submit to examination, the author believes that the necessity for such an examination should be made clear to them.

"This brings us to a consideration of the neurosyphilitic and marriage. A doctor's hesitation to divulge the fact of neurosyphilis to the future mate shows an individualistic rather than a community point of view. The chances of conjugal infection from neurosyphilis are slight, yet at best a neurosyphilitic is not apt to be a satisfactory husband in the light of probable loss of mental capacity and inability

to support a home. Let the future spouse be supplied with all the facts as a basis for judgment. Syphilis need not figure in the discussion as a moral disease or stigma. All information should be given verbally as a protection against legal action for slander."

As to who shall give the information, the best person to do this is the physician on the case. Where the physician cannot do this and there is a choice between not telling and delegating the authority, the social worker should, the author believes, receive "permission from the doctor to give out the information necessary in order to bring about treatment or family examination. Many doctors hesitate to give this permission, fearing some family trouble as a result or some accusations against the organization. There is always a modicum of risk, but I feel that the time has come when the doctor must assume this risk. It implies chiefly confidence in the social worker's intelligence and skill, and willingness to stand by the principle of telling the truth. There can be no real advance in the work unless this is done. The federal and state authorities have set the precedent of more frankness and it seems to me that the doctors and hospitals should follow suit. No family upheavals nor any undue unhappiness has resulted from our handling of several hundred cases in this manner."

In answer to the question how the results of syphilis—familial and economic—may be combated, the author has this to say:

"By diagnosis, made possible by family examination, the spread of the disease can be checked; symptoms can be anticipated, and hope can be offered for healthy children if treatment is applied to the parents before the children's birth. Much can be accomplished by coöperation between the doctor and the social worker, social agencies, social legislators, employers, and employees, and by education of the public to the recognition of syphilis and neurosyphilis as a family and a social rather than an individual problem."

The Present Attitude of Employees to Industrial Psychology. By Susie S. Brierley. *British Journal of Psychology,* 10:210-227, March, 1920.

The writer approaches this analysis of the antagonism of organized labor to industrial psychology with the point of view that an understanding of this antagonism cannot be reached by a study that confines itself strictly to the world of industry—that the attitude of the worker toward his work is not determined purely by economic considerations such as hours and wages, but is conditioned by the many social and ethical relationships of a complex civilization. The "economic man" of the economist has no meaning for the psychologist;

he must "face the whole problem of human nature in industry," must remember that "from the larger social standpoint, the laborer is not merely a factor in production, but himself gives meaning to the process of production. Not only are his material needs to be met directly or indirectly by what is manufacturred, but his life, the life of a human being, is to be expressed in the social medium that his work conditions provide. The office, the factory, and the workshop are part of the field in which men and women live out their human relationships, part of the means by which citizens exercise their civic functions, part of the education by which they grow to full moral height, and the psychologist must remember these wider aspects if he is to understand the worker's responses."

From this psychological standpoint, the writer discusses what seem to her the main factors that determine the attitude of the workers, and especially the educated among the workers, to scientific improvements in management. Briefly, these are as follows:

(a) Suspicion on the part of the workers of the motives behind the attempt to change industrial practices. This is due partly to the normal functioning of the herd instinct and partly to a caution born of past experience. "This distrust is, moreover, subject to a pathological exaggeration, which itself serves to intensify the antagonism." In regard to this pathological element, the author notes "the suggestion made by Mr. Graham Wallas, and developed by Mr. Ordway Tead, in special reference to the life of the industrial classes, and supported also by many general considerations of pathology and physiology—namely, that it is the dispositions which that life 'balks,' the instincts which it represses, that give rise to the pathological element in their reactions."

(b) Jealousy for the solidarity of workers. This is partly a manifestation of the herd instinct and partly a rational fear "of anything that holds possibilities of the weakening of trade unionism and of danger to the hard-fought-for principle of collective bargaining." In the writer's opinion, it is the intelligent, educated workers who are most opposed to the introduction of any methods in industry that would be likely to weaken the general organization of labor. "The educated workers know how intimately the progress and welfare of their class have depended upon group organization, and they understand, moreover, that the general good of society is enhanced by improvement in the standard of life of its laborers. The mere herd impulse is thus with them largely transformed into an intelligent conjunction of purposes." The industrial psychologist can best obtain their coöperation and good will, not by the appeal of immediate personal advantage, but by convincing them that the whole labor world will benefit permanently by the new methods.

(c) Fear of increased monotony. In discussing this and the two succeeding factors—(d) dread of loss of craftsmanship and (e) emphasis on the value of human personality—fundamental difficulties are encountered whose significance cannot be appreciated "without going out beyond the bounds of the workshop into social and civic relations." This set of influences may perhaps be summarized in the statement "that the workman, stimulated by the growth of political democracy and by a measure of education, has arrived at and holds firmly to a conception of his own human dignity and of the basic value of human personality. This is now so vital to him that he dreads and resists any industrial development which appears to him to hold possibilities of increasing the already crushing effects of industrial life upon that personality."

It is a widespread belief among workers, for instance, that "the analysis and re-synthesis of operations by motion study and time study" will inevitably tend to increase the monotony that has arisen in modern industry as a result of the subdivision and mechanization of labor and the stereotyping of operations. "The psychologist," says the author, "usually makes the rejoinder that the monotony is there in any case, that the workers will fall into some stereotyped habit or other, and that it is better that that habit should be an intelligent one, based on science rather than on accidental circumstance. Such a reply appears to be sound argument provided one takes the monotony to be inevitable. And it is extremely difficult to see how it can be obviated for the great mass of workers in large-scale industry. Yet it appears to me that in falling back on its inevitability, we are rather shirking the psychological issues. It might conceivably turn out to be true that on psychological grounds the far-reaching effects of continued monotonous occupation were so dangerous to members of a highly complex civilization as to make it worth while to reorganize our methods of production, root and branch. I do not suggest that this is so, but only that it might be so; and that it is for the psychologist to develop its full implications."

The fear of a still further loss of individual craftsmanship as a result of the new methods is closely connected with the fear of an increase in monotony; both are fundamentally a dread of any process or policy that may lead to the further dehumanization of the worker—that may tend to make him still more of a tiny cog in a vast machine. To the psychologist's argument that the scientific study of industrial relations does not create the specializing tendencies of industry—which are inevitable in any case—but simply seeks to "reap the fullest advantage of modern machinery while avoiding its evils," the workers answer that this is a matter of the spirit in which the study is un-

dertaken. What are the ends that the industrial psychologist has in view—the narrow one of increasing production or the broad one of increasing human well-being and happiness? To what is he giving first consideration—things or men? "They do not deny the need for production, but demand some social guidance of the purpose in relation to moral ends. Moreover, they are seeking to find in their daily occupation a true vocation—one which shall develop them further in their manhood and employ the balanced powers of mind and body," and they are arguing that "the assumption by the worker of some measure of genuine control of industrial processes is the only way in which it is possible to restore to the vast, dehumanized machine of modern production any true satisfaction for the workmanly and creative impulses of the bulk of those whose destiny it controls. This is their answer to the problem of over-specialization, to the question of how the technical psychology of industrial processes can be made to serve the greater human purposes."

The writer does not attempt to discuss this highly controversial subject of giving the workers a share in the control of industry. She simply points out that their demand for it is a psychological question, and that it is the business of psychologists to deal with it not by labeling those who make it as mere "agitators," or at best as "idealists," but by inquiring what psychological influences lie behind the demand. Her own interpretation is that "this conscious self-assertion and the desire for self-government in industry are the inevitable outcome of the growth of political democracy, of the complex demands that civic and national life is now making on the personality of all its members, and of the wider and freer education that recent years have brought to many," and she questions whether it is "psychologically possible to have docile, externally controlled workers in industry who are yet free, intelligent, and responsible members of a democracy outside it."

Her conclusion is a plea to psychologists to face these larger, more vital issues: "The workers come to psychology as to the human science, the science which, whatever else may be prostituted to meaner ends, will of its essence consider the whole man in all his relations. It is for us more than for any other science to lend our knowledge for the re-creation, not only of industry, but of human society. To do this we must see the lesser in relation to the greater and keep our vision whole."

BOOK REVIEWS

THE ADOLESCENT GIRL. By Phyllis Blanchard, Ph.D. With an introduction by G. Stanley Hall. New York: Moffat, Yard, and Company, 1920. 242 p.

This very interestingly written book sets out "to provide the adolescent girl with definite information concerning her own nature and the powers that are latent within it, and to point the way to a proper utilization of her energies." The book reflects a strictly genetic point of view, and psychoanalysis is definitely accepted as the method of approach in studying and managing the problems of adolescence. Since very little dependable information is at hand concerning the nature and mechanism of adolescence in the girl—according to Hall, "the psyche of the budding girl has seemed about the very most unknown of all the great domains of psychology"—there is undoubtedly a great need for a book which attempts to throw light on this important subject.

The author has the unqualified endorsement of Professor G. Stanley Hall, and the excellent manner in which she has handled the extensive literature on genetic psychology ought to bespeak for her book wide and serious attention.

To the reviewer the book commends itself most particularly on account of the richness of first-hand clinical material, put in a simple, readable manner, the frankness with which the author has handled the subject of the instinctive determinants of conduct, and finally because it reflects throughout a "mental hygienic" rather than a therapeutic aim. It sets out to "educate" rather than to "medicate."

Agreeing with Hall's conception of the phenomena of adolescence—namely, "as the entrance of the individual into the larger life of the race, so that the psyche reverberates with the phyletic memories lying deep within the nerve plexuses and ganglia of the subconscious far below the level of consciousness; feels the impulsion of irresistible forces which urge the boy and girl to express in their own person the myriad activities which have characterized the stirps in the long æons of development; and is flushed with that mighty creative energy which has forced the living organism to ever higher forms of existence and now impels the adolescent to be and do all things in his own person," the author does not believe that these phenomena can be sufficiently explained by the physiologic and metabolic changes, but that genetic psychology might offer much help in understanding their significance.

With this in view, she summarizes in one of the clearest and best statements we have ever seen the contributions of Freud, Adler, Jung, Maeder, and of some of the philosophers who have concerned themselves more directly with the nature of the life impulse, and sees in the conflict between the strivings of the egoistic and the racial instincts for the domination of the personality one of the main causes of the "storm and stress" of adolescence. She pleads for a frank facing and recognition of the "unconscious elements" which have so much to do with the shaping of the adolescent's strivings and tendencies, since then only is there a possibility of utilizing these forces for higher and socially valuable purposes.

"Because these deeper racial instincts have so long been unrecognized and unclassified, the adolescent girl's rebellion against the influences that tend to cramp her development is misguided by the adoption of a false set of standards, so that instead of seeking an expression of her own peculiar nature and making her own unique contribution to the race, she has sometimes attempted to follow the man-made path instead of blazing the trail for herself. Only when she awakes to the fact that her rôle in the world order is as primeval and significant as man's, only when she solves the conflict within her soul by yielding completely to her deepest emotional nature, will she achieve the proud position for which she has been longing, and find herself forming a part of the dual power which is needed for racial salvation, a power in which the quick sympathy of woman supplements the slower intellectual guidance of man; and it is only as she attains this position, which is so entirely in harmony with her whole being, that the adolescent conflict in the individual and in the race will be finally and rightfully solved."

The intimate self-revelations of young college and university women quoted by the author add very much to the value of the book, which might be read with considerable benefit by every one interested in this problem.

Bernard Glueck.

New York City.

The Self and Nature. By DeWitt T. Parker. Cambridge: Harvard University Press, 1917. 316 p.

In spite of the doubt that the vast accumulation of knowledge has cast upon the possibility of attaining to a view of the whole of things, attempts to arrive at such a view continue to be made. A recent example is DeWitt H. Parker's volume, *The Self and Nature*. For a metaphysician, Mr. Parker is remarkably short-winded. He takes only a little more than three hundred rather small pages to record

his "first-hand attempt to think through the great problems of philosophy" and to "project a total vision of the world." Nevertheless, he aims not only at the "integration" of the larger facts and broader generalizations of science, but at their interpretation through a comprehensive analysis of experience—of experience not as given, but as imaginatively extended through the following-up of motives found within it, but leading beyond. This was for him "a personal, an unavoidable quest, an intellectual adventure," and the book is an invitation to the reader to follow the author's trail.

The thing about Mr. Parker's book that strikes the reader at once is not commonly associated with philosophers: his style is clearness itself; it is entirely free from the professional jargon which has tricked many into believing that they were developing ideas when they were only beading words. Moreover, while the author has obviously lived with scholars and books, one gets the impression that he is very much at home out-of-doors. Woods and winds and wild flowers nudge his elbow as he writes, and the blue sky visible through his study window (it seems never to be clouded) is as intrusive as the sound of his typewriter. If one may venture another and a somewhat more hazardous guess, it is that he is less interested in the man in the street—in that swarming covering of the earth generally referred to as "the masses," but secretly often spelled with the *a* changed to an *e*. All of which guesses are suggested by a personal quality in the author's style which saves this discussion of abstract philosophical problems from being in the least abstract. Whatever else may be said of the book, it is readable and understandable.

One sacrifice made by Mr. Parker "for the sake of simplicity and continuity of writing" is deplorable—namely, his repeated failure to indicate what particular author he is criticizing and where the passage objected to may be found. It is not my intention to suggest that Mr. Parker's book should have been longer. Heaven knows, brevity is not a fault of metaphysicians. But the trail the reader is invited to follow is much too easily lost owing to the author's habit of making short cuts through difficult territory. Indeed, for all the reader can tell, the author himself may at times be lost. In the Foreword, to be sure, Mr. Parker excuses himself for not making more acknowledgments in the body of the text. He is moved to do so, however, by a gracious fear that he may not have made sufficiently clear his indebtedness to his teachers. Another reason for a generous citation of authors does not seem to have occurred to him. The reader might be interested in the author's views, not primarily for themselves, but as a contribution to philosophical discussion. On account of its shortness and the nature and range of its subject matter, the book is full of highly condensed statements of other men's views. And since

there is often no indication as to how the author's criticism of these might be followed up—indeed, since sometimes it is quite impossible to determine the identity of the writer under criticism—the book, unless thought of as an enlarged seminar report, invites to superficial rather than to thoroughgoing consideration of the problem. It appears that Mr. Parker was sufficiently aware of his obligation to his teachers, to his "chief," and to himself, but not to the serious student of his work.

The most pithy chapters in the book (which one wishes had been more fully done at the expense of others) are those devoted to the discussion of self, mind, and personal identity. Mr. Parker rejects the pure ego concept of the self to which all experience is said to be given, and backs up his rejection with cogent argument. He defines self as a unit of activities such as instincts, purposes, choices, satisfactions, dissatisfactions, opinions, thoughts, memories. Images, however, and bodily feelings of all sorts, while intimately associated with and inseparable from these activities, are held not to be part of the self. Still less so are colors, shapes, and sounds. The self experiences—or, as Mr. Parker puts it, finds—colors, shapes, and sounds, and this finding is evidence of a close tie. Which brings us to the author's distinction between self and mind. "I find myself connected with all found things," says Mr. Parker, "in a way which does not exist between me and things which I do not find. I find, of course, thoughts of these latter things—a thought of my reader and New York, for example; but what these thoughts mean, the things themselves, I do not find. The things which I both mean and can find—the blue of sky and sound of typewriter, for example—are all in contact with one another and with the self, with the thought that means and the pleasure that is taken in them; but between the things which I mean and cannot now find and those which I do find there is no such contact. . . . There is, therefore, a contact of the self with things which are no part of it; with these it makes a whole from which all things which it cannot at the moment find are excluded. Let us call this whole of things findable a mind or consciousness." The mind is thus a whole constituted of the self and what the self finds. This latter may be called content. "The activities are interwoven among themselves and with the content, and this woven web is the mind."

To establish this theory of the self, Mr. Parker employs a lighthearted logic that is disappointing. There may, for example, be a good reason for calling thoughts a part of the self and images not, but the reason is not obvious—if it exists. One's thought of New York is, according to Mr. Parker, a part of the self; then why not such images as one has of the metropolis? One may, of course, define the

self as one pleases, but if discussion is to arrive anywhere, distinctions should be made according to some principle. The principle used by Mr. Parker is elusive. One concludes at first that everything is a part of the self which, if thought out of existence, would take the self with it. This is the reason given for making interests, thoughts, purposes, opinions, etc., parts of the self. But it seems rather clear (unless one arbitrarily will not have it so) that to think away images, bodily feelings, etc., does like violence to that mysterious complexity one refers to as oneself. One concludes next that the test is intimacy of contact. We are told that "my strivings are always inwrought with strains; my desires are always hugging some image of shape and color; my pleasures and pains are penetrated with organic pressures and touches; my thoughts and memories are constantly interwoven with pictures of their objects. And this intimate relation of all these doubtful things to the activities is, I think, the ground of our identification of them with the self." Moreover, the self is never confused with what we ordinarily call things, "because never in so intimate connection." But, again, it seems purely arbitrary to hold that my thoughts and memories are more intimately mine than "the pictures of the objects" without which the thoughts and memories cease to exist. A third test appears to be suggested—namely, appropriation. We somehow "own and appropriate" our opinions, which thereby become part of the self. Well, do we not own and appropriate our images and our organic pressures and touches? I am not contending just now that images, organic feelings, etc., must be included as part of the self; in other words, that the author gives the best definition of self in a moment of forgetfulness (unless I misread him) when he says: "The self consists of the activities, of striving, feeling, and thinking, in their various modes and with their attendant images and organic reverberations." I am here concerned with the writer's logical method. I am saying that in a book proposing to think through the great problems of philosophy, the author shows too much of a tendency to rely upon his *ipse dixit*.

The point is so central and the defect so characteristic of the book as a whole that a few more illustrations are in place. As one of these, we may take Mr. Parker's way of meeting the contention that the self includes not only what he calls activities, and not only images, feelings of stress and strain, but also colors, sounds, odors, and so on. "This whole is often called the self," says Mr. Parker, "but improperly; for the self, as we have seen, is only one part of it." Of the same style is his interchangeable use of "found" and "findable" in referring to the content which, together with the self, makes up the mind. "I find myself connected with all found things [the blue sky and such of the typewriter as I see] in a way which does not exist be-

tween me and things which I do not find [my reader and New York]." "Let us call this whole of things findable a mind or consciousness." Now the trouble is that found things and findable things are not interchangeable in everyday life. Obviously, while the part of the typewriter which is not seen, the reader, and New York are not found and thus are not part of the self, they are all findable and thus are part of the self. Nor is this criticism a fallacy of accident, since it is upon the distinction between found and not found or between findable and not findable that the author bases his doctrine.

Finally (to limit ourselves to one more example) in meeting the objection that the reduction of the self to activities destroys the self's unity, Mr. Parker holds that this criticism has its basis in an exaggeration of that unity, and goes on to say: "At any moment the self is a whole complexity of interwoven acts; yet there is sufficient independence among them to permit of the direction of one upon another. In other words, a part of the self discovers the rest." Would it be unfair to ask, in passing, whether this is what is meant—that a man is constituted a unified self at, let us say, the breakfast table in that his desire for a lump of sugar in his coffee is also directed upon his curiosity to know whether Babe Ruth made another home run yesterday, and this latter in turn upon his more or less vague consciousness of after-breakfast duties, and so on? At the moment when one activity discovers another, Mr. Parker continues, "I am at once the act of the discovery and the other acts." Undoubtedly; but that is merely a restatement of the problem. It in no way shows how the desire for sugar in coffee, curiosity about Babe Ruth, and consciousness of duties to be done discover one another. "This," as Mr. Parker well says, "is undoubtedly a difficult situation, as every psychologist knows, and is the source of all uncertainties in the theory of the self." And the difficulties and uncertainties are not cleared up in the least by the assurance that "the difficulty is not insurmountable and we do actually find our activities," nor by what follows. For after a destructive criticism of various theories that purport to account for the self's unity, we are told: "Well, the unity of the self is open for any man to inspect; let him compare the appropriateness of the expressions which we shall use to describe it with the evidence of his own experience. The unity, we say, is an interweaving of the activities. It is nothing besides them; it is a growing together of them, an interpenetration of them. Just as color and shape are grown together in a flower, so thought and feeling and striving are grown together in the self." It is nothing to Mr. Parker that the "grown together" in the case of the flower is a totally different thing from the "grown together" in the case of the self. Such little matters are forgotten under the spell of metaphorical language. Or per-

haps the color of the rose discovers its shape, the shape of the rose its odor, the odor again the color. One thing is clear. No man who feels it necessary to assume a self back of experiences to unify them will be persuaded that Mr. Parker has suggested a possible alternative.

To stop at this point in the analysis of the book would leave an entirely erroneous impression. Mr. Parker is an original, provocative thinker and the student of his book will find it the *terminus a quo* of any number of interesting speculations even should he be unable to persuade himself that it is an acceptable *terminus ad quem.* That the author's ventures are in general lacking in evidentiary support in no way detracts from their suggestive value, as it in no way proves them unfounded. Indeed, if one must choose between an intellectually daring and a logically rigid philosopher, there is much to be said for choosing the former. Mr. Parker is something of a dare-devil in philosophy. One may or may not regret that he risks himself in his high performances without spreading a net beneath, but one is at all events assured a thrilling experience. Take, as an instance, his contention that time intervals mean interruptions, but not necessarily change in the thing interrupted. As Kant argued that existence is not a quality of objects, but a relation of the objects to some system of reals, so Mr. Parker may be said to argue that time is not a quality of objects, but a relation they bear to one another—a suggestion that blows over the arid discussions of the time problem like a fresh breeze over August fields.

With this conception of time as key, Mr. Parker is prepared to offer to the reader an equally refreshing discussion of personal identity. Why is there a problem of personal identity? We first conceive of time as a series of unique moments, he says, and then, since separate experiences must take place in different moments, they are conceived to be necessarily unique. Thus the self is shattered into bits, into bits beyond repair. "The whole difficulty rests," is Mr. Parker's interesting suggestion, "in the supposition that the present thing has its double back in the past; that there are two existences which, *qua two,* cannot be identical. But a difference in moments," he continues, "does not argue a difference in existences; for the same thing may exist at many different moments and quite irrespective of whether they are continous or discontinuous. . . . When an experience disintegrates, it ceases to exist absolutely; but now this very thing may be reintegrated; that which ceased to exist may come again into existence. And its sameness is not of mere quality as distinguished from numerical or existential sameness. . . . But the very stuff of the old is born again, and when reborn, is the same past thing which was destroyed and ceased to exist until now."

Perhaps this is sufficient to convey something of the independent, creative character of Mr. Parker's work. A like quality characterizes the chapters entitled *Causality, Space, Time,* and the brief deliverance of a detached soul which forms the conclusion of the volume. Nor is it my intention to imply that these novel and stimulating ideas are thrown out at a venture, that they are like Melchizedek, without father or mother or descent. On the contrary, they are often enforced by penetrating analysis and rigorous ratiocination. At the same time the feeling persisted throughout the reading of the various chapters that something remained to be done to give the work solidity; that the author was somewhat too ready to take it for granted that the issue had been closed when it had only been fairly started. This characteristic of the book suggested an occurrence in a nearby city. The analogy must not be too seriously or strictly taken, but it is not entirely without point. A well-known character in this city, otherwise normal, felt himself to have been selected by God to repeat the original creation of man out of earth. Many were the hours he spent on the lake shore devoted to his divine commission, but wind and weather and small boy were persistent obstacles to the completion of his task. On a certain lucky afternoon, however, he made unusual progress. The next morning would see the long-desired consummation. Alas, catastrophe again overtook the work! Coming to the beach when the first blush of dawn touched sky and water, he missed the familiar shape he had left the night before, while moving about near its former place he descried the appearance of a man. With tears in his eyes, he stepped to this figure and moaned:

"Oh, friend, what made you walk off before you were finished?"

M. C. Otto.

University of Wisconsin.

Mental, Divine, and Faith Healings. By J. Macphail Waggett. Boston: Richard G. Badger, 1919. 259 p.

In his preface, the author sets forth his problem as being an inquiry as to the nature of "divine healing, faith healing, mental healing, and the like;" whether they express the influence of some transcendental power or whether they are the result of recognizable natural processes; if the latter, how are the cures brought about and what are the limitations of such methods? Scientifically treated, these problems should furnish material for most valuable studies. As a matter of fact, what the author offers us is the conclusion that faith on the part of the patient determines the success of all cults which attempt religious treatment of disease, and that the proper field for such labors is that of functional nervous disorders, while the

health of individuals suffering from some organic diseases may be improved by similar procedures. In other words, his solution is in terms of what most intelligent laymen know and have known for years.

The book is a queer mixture of mystical visions and parables, in which the author describes the psychology of the unconscious and of suggestion; of banal exegetical discussions of the New Testament and descriptions of Christian Science, New Thought, etc. As a climax, a philosophy of life is offered which is not likely to create much commotion by its novelty. It amounts to this: Make the best of life and you will get the most out of it.

The style is ambitious from a literary standpoint, but commonplace in execution. Further, it is marred by occasional gross carelessness, as when the author uses the word "psychopath" for psychopathologist. It is difficult to imagine any one but the author finding either inspiration or instruction in these pages.

JOHN T. MACCURDY.

New York City.

HUMAN PSYCHOLOGY. By Howard C. Warren. Boston: Houghton Mifflin Company, 1920. 460 p.

The essential function of this volume is to give the student of psychology a mastery over some of its conceptual tools. Few will be found to dispute that this has been well done. The discussion of "attitudes" in particular is a conceptual addition of the first importance. The "attitude" toward the extreme behavioristic position is very just; nor does the analogy of the humoral doctrines and the data of modern endocrinology escape critical notice. One may rejoice, more than for ninety and nine good behaviorists, in the definition of psychology as concerned with "the events which occur in the active give-and-take relations between organisms and their environment." The book bears evidence of the great teaching experience back of it, and with its frequent summaries and synoptic classifications is excellently adapted to the teaching of its subject matter. To the student who does not follow the book in lectures, a most helpful feature could be added in a comprehensive glossary of technical terms, giving their comparative definitions with a fair amount of detail.

Within these limits and for these purposes, the volume may be cordially recommended. It is possible that no better book of its kind will be subsequently produced, as most of those who now take up psychology are not trained to capacity for the type of thinking that the production of such a book demands. From this angle the question must be raised of how far this book, offered as introduction to a

fast-evolving science, really represents the current trend of thought in that science or the considerable changes that have come over its aspect in recent years. It seems scarcely so representative to "let off" the matter of ideational and motor testing with half a dozen pages, or to give the sexual reactions about one page out of 446. The dominant feature of the last decade in psychology has been the establishment of contacts with concrete problems of human behavior. Professor Warren's department has not been without its own contributions thereto, and the brief allusions to the applied field are characterized by the critical insight to be asked of the specialist in it. Plainly the author is far from ignorant of much that he chooses to pass by; but this hardly removes the objection that the book is not representative of what contemporary psychology is, however it may reflect what certain authority would prefer to have it. Accordingly, the text is too like a set of directions for manipulating concepts. In teaching from it, a great deal will depend on how much is made of the "exercises" that accompany each chapter. Objections to the over-conservatism of the text will practically disappear if enough is made of these—enough being much the major part.

In sum, this is a most scholarly work, which in the beginning, and generally in outward semblance, gives promise of breaking fairly away from the traditions that produced the behavioristic schism, but which is found to be still heavily burdened with the inheritance of formalism, only partially offset by its clearness, criticism, humor, and tolerance.

No one informed on the matter regards the objection raised as characteristic only, or indeed chiefly, of the present volume. The scientific mind is not always averse to haggling over definitions of abstractions in terms of each other. Psychology has had all its share of sophisticated dialectic, the heritage of what Jung called the sublimation of mythology. The unsublimated equivalent is the story told of the ecclesiastical body which had just abrogated a doctrine of infant damnation.

"Now, gentlemen," exclaims one of the assembly, "I move this be made retroactive!"

F. L. Wells.

McLean Hospital.

The Psychology of Dreams. By William S. Walsh, M.B. New York: Dodd, Mead, and Company, 1920. 361 p.

This book was written for the general reader, with a view to promoting a better understanding of normal and abnormal mental processes. There are seventeen chapters, all of which deal with various

aspects of dreams. The author gives a historical sketch, and mentions one of the first of ancient theories in regard to the dream state—that of Hippocrites, 460-354 B. C., who thought that in sleep the soul stole over the body, seeing, hearing, touching, reflecting, grieving, and that such activities constituted dreams. The author has given data from many of the present-day psychoanalytical works, of Freud, Brill, and others.

The chapters deal with *The Mind in Sleep, The Material of Dreams, The Instigators of Dreams, Dreams as Wishes, Typical Dreams, Nightmare, Daydreams, etc.*

The chapter dealing with daydreams is especially interesting and instructive and, like the other chapters, is written in so clear a manner that the beginner will have little difficulty in becoming acquainted with the dream mechanism and its meaning. However, it would seem that such a subject would demand more detail, especially dealing with the disastrous results that follow daydreams, and it would be well to show broader methods by which these abnormal states could be aborted and the striving directed into more constructive channels.

On the whole it can be said that the work is an excellent medium for the student who wishes to become acquainted with the workings of the unconscious, and that it should prove helpful to the layman, who, by reading its pages carefully, can gain an understanding of the mental processes that control to a greater or less degree our daily actions, making us productive or deficient as the case may be.

L. Pierce Clark.

New York City.

Personal Beauty and Racial Betterment. By Knight Dunlap. St. Louis: C. V. Mosby Company, 1920. 95 p.

This book is stated to be a brief and clear presentation of the central problems of eugenics, as seen from the viewpoint of physiological psychology. It consists of two parts: (1) the significance of beauty, being the reprint of a lecture, and (2) the conservation of beauty. In the first part, the author refers to racial characters and racial antipathy; also to the dislike of a significant deviation from the average, of which the antipathy toward racial differences would seem to be a special case. He refers, also, to disease, deformity, and mental and physical weakness as peculiarities that are usually shunned in marriage. He describes in some detail the reaction of young people toward stature in other young people, of bodily proportion, features, hair, fat, complexion, muscular tonicity, and poise, and he finds a biological and eugenical value in those conditions that will most generally be selected.

Part two deals with the conservation of beauty. The author states: "Human beauty, as we have pointed out, is a sign of fitness for parenthood; fitness to propagate children who shall be able to hold their own in the mental and physical struggle with nature and with their human competitors. It is the sign which is intuitively recognized by the race and upon which the process of sexual selection is based. It, therefore, is nothing superficial; it is the external appearance of the germinal potentiality which is the most important of all things for society."

The author notes that the progress of civilization has obstructed the propagation of the fittest and facilitated the multiplication of the unfit by the development of surgery, pharmacology, and prophylaxis with large funds and personnel to apply them. Thus the less resistant, the less virile have been given a greater ratio of survival.

A second way in which civilization interferes with the conservation of the desirable human qualities is in setting sexual values that conflict with those of beauty and that obscure and override them, such as desire for economic advancement or the fulfillment of special ambitions.

He considers practical steps in conservation, and of these he regards education and publicity as all important, as leading to a reduction in the number of cases of marriage of the feebleminded and those with hereditary insanity or criminal tendencies. He doubts if sterilization will ever become popular and sees a danger that, as it should, it would be placed in the hands of the medical profession *as such*—a guild whose "rank and file are properly ranked as skilful technicians and not above the average of the middle-class in intelligence and morality. The commission to such an organization of such sweeping control as is contemplated by the proponents of sterilization would be a political revolution of a most portentous nature." Dr. Dunlap believes that some improvement in sexual selection can be brought about, though not by Plato's scheme, in which the state cares for offspring, as all experience shows that an institutional care of babies can never replace the parental instinct. He would wish to see a decline in births among the classes unduly multiplying, but how to bring this about is the rub. He refers here to the over-limitation of offspring on the part of the most beautiful and effective. He finds cause for regret that so many public entertainers, such as actresses, singers, chorus girls, and dancers, should be withdrawn from motherhood and child rearing. The author concludes that the "conservation of beauty is *the* problem of to-day and of all time," and believes the solution of the problem to lie in education and publicity.

The foregoing essays are well written and attractively presented. The general point of view is, of course, not novel, but there are de-

tails of observation and reflection that make the book well worth publication and wide reading. No doubt there are statements of opinion which are merely such, and not based upon a proper body of fact. A difference of opinion might be allowed on certain points, such as (p. 20) "all dark races prefer white skin." No doubt mulattoes do, but there is abundant testimony that the full-blooded negro prefers mates of his own color. Again, the author is somewhat embarrassed by the fact that women show a preference for large stature, though he thinks that they prefer mates whom they can control physically and in every other way, for "the instinct to dominate is inherited in every human being." One wonders if that is good psychology and if the instinct to be dominated is not widespread especially among women. Is it true, also, that (p. 79) "the wealthier the match, under present conditions, the less the probability of [the beautiful woman] bearing children"? A limited experience would seem to indicate that the restriction of children is commoner in people of moderate income than in the very wealthiest. With the main conclusion of the author it is believed there will be little dispute—namely, that progress in the conservation of beauty can be made by education and the gradual building up of eugenical ideals in the population.

Charles B. Davenport.

Cold Spring Harbor.

Hypnotism and Treatment by Suggestion. By Albert E. Davis, Hon. Physician to the Liverpool Psychotherapeutic Clinic. Liverpool: The Liverpool Booksellers Company, Ltd.; London: Simpkin, Marshall, Hamilton, Kent, and Company, Ltd., 1919. Second edition. 124 p.

It is important for the advance of the mental-hygiene movement that the layman should have a thorough working knowledge of what modern psychotherapy can do. This little volume presents in a sketchy, but convincing way the progress of medical science of recent years in treating, not only difficulties which appear on the surface to be psychological in origin, but also many others which the layman is apt to regard as physical disease. For one who is totally unacquainted with psychotherapy, this book should be an excellent introduction to knowledge that it is essential for all thinking people to have. The title is somewhat misleading, in that it gives the impression that only one method is discussed, whereas the author outlines analytic as well as suggestive methods of treatment. He is evidently a highly practical and successful physician who believes as much in alleviating the symptoms of incurable disease as in curing such neurotic difficulties

as may be entirely removed by psychotherapy. His publication is therefore of particular value, inasmuch as it demonstrates how quacks of various kinds are successful in dealing with organic disease, for he explains clearly that there is a large functional or psychological element in the suggestive symptoms of many somatic ailments.

Such adverse criticism as may be made is of details which are rather inevitable defects of the style in which the author has chosen to present his subject. Writing for the layman, he is apt to make rather broad and careless statements which might arouse the antagonism of the critical mind of the professional reader. In describing the unconscious, for instance, and its capacity for intelligence, he talks of the unconscious recognizing a disturbance of protein metabolism, and in virtue of this knowledge correcting the appetite of a patient with such a disorder. Graver mistakes are made in his speaking of chorea and anæmia as functional diseases in a way which might lead the lay reader to think that these diseases never have any organic basis. Such a misconception might prevent a patient from seeking prompt and expert attention. On the other hand, he repeatedly urges the necessity of all psychotherapy being left in the hands of well-trained medical men alone.

This book, then, can be recommended highly to the layman who seeks a preliminary knowledge of the field of medical psychology, although it is too simple, too sketchy, and perhaps too carelessly written to satisfy those who are interested in psychotherapy as an exact science.

John T. MacCurdy.

New York City.

Education During Adolescence. Based partly on G. Stanley Hall's *Psychology of Adolescence*. By Ransom A. Mackie, M.A. With an introduction by G. Stanley Hall. New York: E. P. Dutton and Company, 1920. 222 p.

This book is to a large extent a presentation of the views of Stanley Hall on the special educational problems of adolescence. The author examines various curricula in high schools and discusses in detail several of the special subjects. A copious bibliography is appended to the book. The book presents in readable form a point of view of very great importance for education; if there is little that is novel in it, it focuses in a useful way a variety of material that is scattered throughout many journals and in many larger books.

C. Macfie Campbell.

Johns Hopkins University.

PSYCHOANALYSIS: A BRIEF ACCOUNT OF THE FREUDIAN THEORY. By Barbara Low. New York: Harcourt, Brace, and Howe, 1920. 199 p.

PSYCHOANALYSIS AND ITS PLACE IN LIFE. By M. K. Bradby. (Oxford Medical Publication.) London: Henry Frowde; Hodder and Stoughton, Ltd., 1920. 266 p.

PSYCHOANALYSIS: ITS HISTORY, THEORY, AND PRACTICE. By André Tridon. New York: B. W. Huebsch, 1920. 272 p.

Each of these books is interesting in itself (at least two of them are), but the three are interesting as a group because each author has set for himself the same task. Each believes that an intelligent public should understand something of psychoanalysis and its personal and social significance. Each undertakes to write a book that will stimulate interest and give this information. Each does it differently, of course. Mr. Tridon in a small book undertakes to explain the theories of Freud, Adler, Jung, and Kempf and then to discuss them in relation to a large variety of things. The result (aside from the exposition of the theories themselves, which on the whole is good) is a series of staccatolike paragraphs in which there is little exposition or discussion—mostly dogmatic statements from which it is practically impossible to differentiate fact from hypothesis or fancy. The book is also marred by a poor selection of material or, one is inclined to say, a lack of selection. What possible good, for example, may be expected from such a chapter as the one on Treatment? One's interest in the subject of psychoanalysis does not grow with the reading of Mr. Tridon's book. Rather, one finishes the book with a feeling of relief that one's duty toward it (and, I fear, a good many will feel toward the subject) is done.

Mr. Tridon will know how to evaluate these criticisms. He will find emotion lurking in them, and that will indicate to him that somewhere he has "hit" one of my own "complexes"! Probably he has. But why should Mr. Tridon give my "complexes" such a whang that I am bound to recoil? He does not wish me to recoil. At least he says so. He wishes to interest me. His intentions, no doubt, were good; put it down to lack of skill.

Miss Low and Miss Bradby wish the same and, so far as I am concerned, they have succeeded. What they have said interests me very much. My interest grew with each chapter, and I find that through both books are checks and comments I have placed there—here a reference to consult, here something of Freud's to pursue further, and on page after page checks with question marks indicating that I wish to return to these paragraphs at a later time for more careful consideration.

Both Miss Low and Miss Bradby proceed to their task thoughtfully. Each selects with care the material she wishes to use and then develops her exposition clearly and systematically. The result is that while one may not agree with all that either has set down, one must needs come away thoughtful (and many, we believe, hoping that much that has been said will eventually turn out to be correct).

Miss Bradby chooses to cover more ground than Miss Low, although considerably less than Mr. Tridon. She confines herself largely to the theories of Freud, although with a considerable independence of thought, and discusses in this connection the unconscious, the theory of complexes with an explanation of various types, repression, dreams and their interpretation, unconscious primitive traits in present-day thought, the place of psychoanalysis in everyday life, and finally the light that may be thrown on biography by psychoanalytic study. Some students friendly to psychoanalysis have objected to the latter form of study, but Miss Bradby's analyses seem helpful. One thinks no less of Nelson or Michael Angelo or Browning after such a study; rather, one has a more sympathetic understanding (granting the analyses to be correct) of traits and conduct that one has previously been inclined, along with the rest of the world, to condemn. Certainly (granting again that the analyses be correct) one is led to understand and to evaluate better some of the things one is inclined either to approve or to blame in oneself, one's friends, and one's heroes. The author's discussion of the steps in sexual fixation (pp. 51-56) is excellent, and special mention may be made also of the chapters *Symbolism in Art and Literature, Psychoanalysis and Evolution, Psychoanalysis and Morality and Religion.*

Dr. Ernest Jones, in a foreword to Miss Low's book, points out the peculiar difficulties in the way of one who attempts the task the author has set for herself. "It is never an easy matter to present a complex science in outline, but with psychoanalysis several special circumstances make the task of simple and satisfactory exposition an almost insuperable one. To begin with, it is a new and growing science, and it is always found that the ease of popular presentation depends on the extent to which a given sphere of knowledge is relatively complete and finished. When fairly stable conclusions have been clearly defined from many angles, it is possible to formulate them in simple language, even though the implications of them may be complex and elaborate enough. During the earlier stages of development, however, when the conclusions are more fluid and less sharply defined [one would never guess from Mr. Tridon's book that psychoanalysis was in this stage] it is very hard to reduce them to an easily intelligible form and to assimilate them to common knowledge, since the bearings of partial generalization are only evident to those

who have already made some study of the subject. This is especially true when, as in the case of psychoanalysis, the conclusions reached are strange and startling; the more foreign they are to familiar knowledge, and the more repellent to preconceived opinions or prejudices, the harder it is to make them either acceptable or readily comprehensible."

Having read Dr. Jones' foreword and the lines from *Bishop Blougram's Apology* (Browning)

> "The common problem, yours, mine, and every one's,
> Is not to fancy what were fair in life
> Provided it could be—but, finding first
> What may be, then find how to make it fair
> Up to our means—a very different thing!
> No abstract intellectual plan of life,
> Quite irrespective of life's plainest laws,
> But one a man who is man and nothing more
> May lead within a world which (by your leave)
> Is Rome or London—not Fool's Paradise."

quoted on a flyleaf, one is already in a proper mood to attend seriously to what Miss Low has to say.

Of what Miss Low has to say one would like to quote a good deal, not only for what is said, but for the way in which it is said. Miss Low has made a painstaking effort at clear conceptions and accurate statements. There is little dogmatism. There is real democracy among her categories. What she believes to be facts sit at the head of the table. Theories, hypotheses, opinions, all have suffrage and sufferance, but they are suitably clothed in what represents their proper state and relative importance to the whole and without pretense stand for precisely what they are. The communism of some books on the subject is missing. Where an opinion has gathered about it a number of friends and has decked itself out in clothes it has filched from some unsuspecting, but more fully developed category, the herd critique is made felt through the powerful, but little word "if." And when, in this spirit, one has read the five chapters, *The Scope and Significance of Psychoanalysis, Mental Life—Conscious and Unconscious, Repressions, The Rôle of the Dream, Treatment by Psychoanalysis* and, coming to the last chapter, finds it headed, not *Social and Educational Results of Psychoanalysis,* but PROBABLE *Social and Educational Results,* one proceeds to it with confidence and interest, and at the conclusion turns to the appendix to select another book from the list of references with which to continue one's study. We know of no recent book better suited for one who wishes an introduction to the study of psychoanalysis.

FRANKWOOD E. WILLIAMS.

New York City.

The Problem of the Nervous Child. By Elida Evans. New York: Dodd, Mead, and Company, 1920. 296 p.

In this book the authoress gives a somewhat one-sided presentation of the factors that are at the basis of the wayward and disconcerting behavior of the nervous child. The psychoanalytic approach to these problems is emphasized to the neglect of other aspects. But if the book is one-sided, it may at least help to correct the one-sidedness of other books which deal too much with the externals of a child's life and too little with the complex forces working in the depths of a child's nature. There is, however, no reason why these forces should not be described in terms that bring the behavior of the child more closely into relationship with general biological reactions. The authoress has preferred to use the rather technical language of the psychoanalytic school.

While her presentation of individual cases and of general principles is not always convincing, the book will stimulate thought on a vital topic. The lay reader will do well to reserve judgment as to the authoress' interpretation of many of the cases.

C. Macfie Campbell.

Johns Hopkins University.

The Good Man and the Good: An Introduction to Ethics. By Mary Whiton Calkins. New York: The Macmillan Company, 1918. 219 p.

Miss Calkins is a well-known contributor to the literature of psychology and philosophy. She writes well and forcibly and unfolds her subject in an orderly manner. The reviewer is, therefore, neither inclined to criticize the subject nor the method of the author other than to speak well of both. It is the viewpoint, rather, that it seems lends itself to critical discussion.

Despite the fact that the preface states that the book is not a "subjectivistic" treatment of ethics, the reader, at least in the person of the reviewer, gains an entirely different impression, an impression that, as a matter of fact, that is exactly what it is. This impression is gained more particularly from the first chapters, and although it is mitigated somewhat as the discussion proceeds, it continues throughout. The whole book might be described as a somewhat labored effort to define the good, the good man, and such concepts as virtue, justice, the beautiful, etc., and while there is much reference to the anthropological sciences for illustrative material, much of the discussion is reminiscent of those Hellenic dialogues wherein a concept was thrashed over and over again until it had yielded its last grain. Such a treatment of the subject is highly idealistic and smacks of the library rather

than the street, and is better calculated for those of a meditative mood than to be of service in the actual problems of real life.

In this day of behaviorism, psychoanalysis, and genetic psychology, it would seem that ethics might well have been approached by tying it up with these several disciplines in a way that would have illuminated it so as to single it out of its murky, scholastic background and identify it for all time as one of the humanities. The author, for example, takes no cognizance of the unconscious origin of activities which have ethical significance except to note that the ethical "ought" is compulsive. It would be a really worth-while service to examine into the nature of this compulsive attribute to find out from whence it comes, its significance, and its value. This alone is, of course, a large order, and many more such might be suggested.

If the book is intended as offering a philosophical foundation for ethics, then it does not take sufficient account of the other sciences; if it is intended for individual guidance, it does not touch deeply enough the problems of human nature. The book is rather a learned discussion of certain ethical concepts from the purely conscious level and from a rich background of learning. It fails in relating this discussion to such practical types of problems as have to be met by those who are actively engaged in matters of mental hygiene.

William A. White.

St. Elizabeths Hospital.

La Crainte du Danger chez le Combattant. By René Cruchet, M.D. Paris: *Extrait du Mercure de France,* 1919. 45 p.

Le Courage Guerrier. By René Cruchet, M.D. Paris: *Extrait du Mercure de France,* 1919. 19 p.

The first study, concerning itself with fear of danger, uses the author's experiences in the great war as its material. Cruchet considers fear as a reflex, with physical and psychical phenomena, arising largely out of surprise. Especially does panic "develop in the critical moments, during intense bombardments, when the field of consciousness is retraced and the man is reduced to a sort of sheep of Panurge, ready to follow passively all his impulses."

To assume indifference, not to be surprised at anything, to shrug the shoulders and to take things as they come is the essence of the prevention of fear and panic—this is the conclusion of Cruchet. It would seem a thing easier said than done.

The companion study takes up war courage as its theme.

The author defines this as the voluntary state which conquers the fear of the dangers of war. He chooses for his human subject the "classical *poilu.*"

He discusses two varieties of courage: the common physical courage, which undertakes great deeds and in which fear is minimum—the active courage—and a type which is not physical, does not manifest itself in deeds, and is subjective—a moral, passive courage.

The French *poilu* was an artist, taking delight in the job, desiring to finish it off with grace and skill, with the little flourishes of the master craftsman. His was the active courage *par excellence*, where the order, the duty, the means of action preoccupy the mind so that there is no fear.

In the moral courage, the desire for the end overcomes the fear after a struggle; there is a real grapple with one's own self, and the action taken has a high ethical value.

In the courage of the warrior there is an assemblage of qualities—physical qualities, intellectual and moral qualities. The brutal discipline imposed on slaves does not create courage; courage comes when free men, accepting the ideals of their leaders, strive to achieve those ideals.

Altogether, two charming little articles.

Abraham Myerson.

Boston, Massachusetts.

Thoughts of a Psychiatrist on the War and After. By William A. White, M.D. New York: Paul B. Hoeber, 1919. 137 p.

Not infrequently physicians have found a means for self-expression in writing books. When these books have dealt with things within their own field of experience or special training, as with biographies or autobiographies or memoirs or, occasionally, with medical history, the result has now and then been important. When, however, the physician has attempted to generalize his special knowledge or to apply it in fields where he can claim no special fitness, the result has usually been dullness or worse because of the exhibition of a woeful lack of knowledge and understanding of the fundamental principles involved or a platitudinous reiteration of facts and opinion long arrived at by experts in that particular field. Eminent exceptions to this statement one, of course, recalls at once—Holmes, Mitchell, Osler, Geddes, and, undoubtedly, Ernest Southard had he lived to complete his work.

One may question, however, what may be the value of any physician's "thoughts" on war and after war. Why should a physician's thoughts on this subject—aside from that part with which he was immediately concerned—be any more valuable than the thoughts of any intelligent, well-informed person who does not think to make a book of them? Isn't it a little gratuitous? Are not the causes of war, and the readjustments that follow, social, eco-

nomic, and political? Must we not look to the experts in these fields for thoughts on these subjects? Their thoughts will be of jealous and antagonistic races and nations, of economic rivalries, of coal and iron and oil and land, of systems such as capitalism and socialism and Bolshevism, of armaments, national revenge, balances of power, autocracy, democracy, and the like. But important as these are they are surely things of the surface, symptomatic of a deeper-lying pathology. What lies back? Statesmen have no answer, but the churchmen tell us that the world has drifted away from Christian teaching, that we talk about, but do not act upon, for example, the Sermon on the Mount. It probably is not impertinent to ask why, perchance, this is so. Why, as individuals or as nations, do we not more nearly exemplify the Sermon on the Mount? Is it sheer perverseness? Are we really marked with original sin as we were once ardently told? Are we stiff-necked in our sinfulness, and have we failed to avail ourselves of the means of redemption? Or are there other forces at work? Forces, mayhap, that tend to make us willful, to make the worse seem the better course, to make us think one thing (the Sermon on the Mount) and do another, that keep us from desiring redemption?

Maybe there are such forces, and if there are, the one most likely to learn of them will be the one who has been studying intimately these problems in their individual setting. This Dr. White has long been doing, and he speaks quite within his field when he writes this little book.

I have intimated a much larger task than Dr. White has set for himself. The book is not a profound book, but is worth while nevertheless. The more valuable, probably, in a general sense, for not being too profound.

Briefly, Dr. White's thesis can be summed up as follows: The human animal, like all animals, has certain fundamental instincts which it spends its life in endeavoring to satisfy. While there are a number of instincts, all of them may be classified into two fundamental ones—the self-preservative instinct (type, hunger) and the race-preservative instinct (type, sexual). The progress of man from savagery to civilization does not consist in the destruction of these instincts, but in the suppression—repression—of the primitive ways of satisfying them and the utilization of the energies so repressed to find satisfaction in ways that are progressively more and more removed from the primitive types. This is the process of sublimation.

When, for purposes of protection, it became desirable for men to herd in bands, there arose the factor of the welfare of the group as a distinct end in itself, often, if not always, of superior importance to the welfare of the individual members. There arise situations, therefore,

in which the interest of the individual and the interests of the herd are not the same, but, the group being more powerful than any individual member of it, the interests of the individual have to give way to those of the group. The instinct to kill, for example, has been sidetracked into a more devious path for its satisfaction, a path beset with all sorts of obstacles from the standpoint of the individual's cravings, but one that serves the interests of the herd far better; this instinct, from being satisfied by actual killing, came to seek satisfaction in the sublimated forms of condemnation, trial, etc.

In this opposition of the interests of the individual in his efforts to satisfy his fundamental instincts and the interests of the herd is a basic problem upon the successful solution of which depends the success of man's efforts to reach even higher goals in his struggle upwards. This is the fundamental conflict which conditions man's activities as a member of society.

In the process of development, instincts, like physical functions, become integrated, the parts in the service of the whole, so that the well-rounded, integrated individual is one in whom all of the instincts operate, but in the service of the needs of the whole individual. When, for example, any one instinct is enabled, for any reason, to gain the mastery of the whole organism so that it dominates its activities, that individual is sick. Activities result which are not useful to the herd, and the individual becomes asocial or antisocial according to whether his activities are negatively or positively injurious to the herd. Integration is in itself a process of development, and failure of integration is, therefore, an indication of lack of development or of relative immaturity. In other words, the domination of any particular instinct is detrimental to the social usefulness of the individual, and therefore tends to unfit that individual for the fullest life as a member of the social group.

The failure of integration brings to bear the herd critique. It represents the force of the herd making for its own ends and compelling the individual to abandon—repress—the immediate gratification of his own instincts. But this force is not only negative, but positive—in that it produces the desire for the reward of social esteem. In the end, the instinct remains the same, but it is applied in more socially acceptable and useful ways; it has become sublimated. *It is, therefore, not the instinct that changes, but its application.* Development might thus be expressed by a description of the objects of interest as they successively replace one another and represent progressively more socially valuable activities.

"The child of two or three years that appropriates something that does not belong to it is not treated either as a criminal or with hate. It is corrected, often in a more or less facetious way, to the end of

bringing it to understand the difference between mine and thine. Our attitude, while one of repression, is also one of education and emotionally is kindly and indulgent. Toward the criminal, on the other hand, it is one of repression, punishment, and hate. Why the difference? It is because in the child's activities we recognize something that belongs to the child period, while in the criminal we see a form of activity which should have been left behind in the process of growth and development, should have become a part of the individual's past. We see the anachronism of an infantile type of conduct in an adult setting. . . . Similarily with other forms of abnormal conduct. We are coming to see in all of them ways of expressing the instincts which are relatively undeveloped, infantile."

We must learn to see individuals, races, species as but reactions of adaption, more or less successfully integrated, to meet the problems which have confronted them in the unfolding of the great creative energy in the face of the obstacles that have blocked their pathways. Conduct must be judged from the point of view of the relative maturity or immaturity of the reacting individual, organ, or group. For certain nations that are as yet in a relatively immature stage of civilization the standard is very different from that of more developed, more highly evolved nations. Nations may have developed to a point that demands higher types of individual and social conduct, but it does not follow that when such nations attempt to unite their efforts into a larger group, a league of nations, the standard will remain as high. Quite the contrary. The higher integration is in a youthful, infantile, primitive, undeveloped, immature state, and so, even though the constituent nations are highly evolved, their group actions may take on the characteristics that we have learned to associate with a relative immature state of development. Lying and deceit of all kinds are pretty well tabooed as types of individual reaction, but they are still in evidence in the diplomatic inter-relations between nations. International relations are higher forms of reality situations which have not yet developed mature and efficient types of reaction that have been laid down in an enduring structure of custom and law. Nations in their international relations have, then, to repeat the story of evolution much as does each child from the moment of impregnation to adulthood. The individual members of the race, however, are already highly evolved as individuals and in this new process of integration are called upon to make adjustments relatively of an immature kind. This necessity for going backward on the path of adjustment has been variously called reversion or regression. It involves a casting away of already acquired adjustments and reverting to an historically earlier type which has been found useful in the past experiences of the individual or the race. In evaluating human

conduct during a period of war, therefore, a distinction has to be made between conduct which is representative of the level already attained by the individual and the level of the race in its newest efforts.

The apparently new phenomena which seem to have been added during a state of war are these phenomena of regression, and they are apparently new because we see them manifest in persons who, as individuals, had always maintained a high standard of personal conduct, but in the new conditions imposed by war become violent partisans from whom reason seems temporarily to have vanished and who, contrary to everything in their past history, become apologists for every kind of regressive tendency.

Such manifestations surprise because we had come to think that they were impossible; in other words, we have thought that the ground gained by culture was gained for all time and so we are always unprepared to see such gross lapses. Our belief that all that has been gained by culture will be held is after all nothing but a wish, and it is because it is a wish, because the belief has back of it the motive power of a wish, that we are so unprepared to find that it is not true, and this despite the fact that we are surrounded by evidences of its untruth all the time.

This matter of regression is one of the most important psychological mechanisms to understand if we are to have any real comprehension of man's cultural advances and setbacks. As conflict arises between the organic needs of the individual and the needs of the group as a whole, the net result is to press all such needs into the larger service of the whole. This outer compulsion to serve the larger end can be successful only at the expense of pressing back, repressing, certain components of the energy representing those organic needs which are not addressed to this larger purpose, but, on the contrary, which are addressed to immediate, concrete, and selfish satisfaction. Such energies can thereafter be effectively expended, in a way satisfactory to both the individual and the group ends, only in a sublimated form, which means that immediate, concrete, selfish satisfaction must be replaced by a more remote, less concrete, and relatively unselfish type of reaction. Repression is an essential feature in cultural progress. Repressed material is essentially the same in all of us. The repressed material goes to form what is known as the unconscious—that is, that region of the mind which makes up its past history, but of which we are not ourselves aware. The essential nature of the unconscious can be summed up in the single word selfish or self-seeking. It knows only its own individual interests and would go to its goal irrespective of anything else. Other individuals' inconvenience, suffering, or even death are of no account to it. Immediate satisfaction of desire by

the means most readily available is its only formula, the seeking of pleasure and the avoiding of pain its only object. The unconscious, therefore, contains the records of our past as we have painfully climbed the road to civilization. It contains those tendencies to gluttony, to lust, to lying and deceiving, to hate, cruelty, and murder which characterize the savage and the child and upon the sublimation of which the progress of civilization depends.

These are precisely those characteristics which we find coming to the front in war time and which, when exhibited by persons we have learned to respect, so much surprise us. The explanation is evident. That great region of our past which we all hold in common has been uncovered and instinctive tendencies which had been repressed now again come to the surface and call for satisfaction. It is the phenomenon of regression. The psychic energy, instead of flowing to outside interests, turns back and refloods the channels along which it flowed in the process of development.

Such an abstract as the above is quite inadequate, but will give some idea of the basis of Dr. White's argument. It is especially worth any one's while to read carefully and thoughtfully the first three chapters, in which Dr. White outlines his thesis. Upon the basis laid in these three chapters he then discusses such subjects as the causes of war, certain tendencies quickened by war, individualism vs. socialism—love and hate, and the socially handicapped. The book is a small one and inexpensive, and while it will disappoint some because of its lack of originality and profoundity, still, if read in the spirit in which undoubtedly it was written—as "thoughts" and not as a discourse—it will abundantly repay. One obtains value received in the first three chapters.

FRANKWOOD E. WILLIAMS.

New York City.

EDUCATIONAL TREATMENT OF DEFECTIVES. By Alice M. Nash and S. D. Porteus. Vineland, New Jersey: The Training School, 1919. 19 p. (Publication No. 18.)

The authors feel that the right educational treatment of defectives has met with only partial solution. With the best of intentions, a great deal of work has been done, but with poor results. "Many school superintendents are content to segregate a greater or less number of children in a special observation or opportunity class, and think that thereby the whole question is disposed of." "Even where the children for such classes are selected on the basis of a comprehensive mental examination, adequate provision for their training is not made by the use of a few woodwork benches and a pile of basketry material, plus a more or less intensive drill in reading, writing, and

arithmetic." The object of the paper is to summarize briefly Vineland's experience in the educational treatment of defectives; its purpose is to record the failures, as well as the successes; it intends to admit frankly that some things are done from expediency and not wholly from right; it purports to discuss why a thing is taught rather than how to teach it.

In the first place, the special class fails, in a great many cases, either because it is not fitting the defective for any occupation or because he does not in after life follow the occupation for which he has been trained. "Children vary just as much in their capacities for manual training as they do in scholastic abilities. In the great majority of instances, special classes are not paying attention to this fact. Teaching a defective some scraps of woodwork or basketry is not helping very much to solve the question of his ultimate self-support."

"There are indirect advantages of special-class work with defectives, the main one being that the regular grades may do better when the feebleminded are eliminated."

The paper calls attention to the right selection of children for training in the various departments. It states that for scholastic training the Binet tests give the best basis for classification. For industrial abilities the Porteus tests give the best indication. Of course Dr. Porteus himself would be as much opposed as any of us to admitting that either one of these series of tests was alone adequate for determining a diagnosis of the individual child, of his abilities, disabilities, and adaptabilities. A well-rounded study of the child from both a psychiatric and a psychological point of view is essential if success is to be obtained in understanding his needs.

The paper calls attention to certain rules that have been evolved from the experience of the authors:

1. Children two years or less mentally (average Binet-Porteus age) are excluded from kindergarten, because they are found to make no permanent gain.
2. Children of seven years or less, Binet age, made no use of reading either for pleasure or profit. Children with I. Q. below 50 should not be given any instruction in school subjects at all.
3. As regards number work, defectives mentally less than nine years, per Binet, unless displaying special aptitude, should be given only the most elementary work. Operations involving the use of pen and paper are utterly useless for such defectives. They either do not use or do not understand such operations.

Speaking of industrial classes and manual training for defectives, the authors highly recommend needlework as a most practical occupation; there is ample demand for workers, and it must contribute eventually, if not to self-support, at least to self-help. They remind

us that woodwork for the great majority of defectives must remain a hobby, its value being seriously limited by the fact that the trades to which it leads are too highly skilled for the defective to achieve competency in them.

They call attention to the great value of domestic-science training—to the fact that it has range enough for all kinds of defective ability and presents to the higher grades a means of livelihood. As regards basketry, they state that it is one of the poorest means of training, it is slow and unprofitable, and it has no future as regards the child. "The defective who can and does earn his living hereby is very rare."

"School gardening on a practical scale is not profitable in the city school systems, where most of the special classes are."

The paper is a very practical contribution to the subject of the training of defectives in special classes, from persons whose years of experience in connection with the education of mental defectives enable them to speak authoritatively upon this subject. The article is well written, concise, clear, helpful, and well worth reading. Throughout it the authors impress upon the reader one most important point—that without adequate supervision of the defective in the community, without proper after-care work, all our laborious efforts in training defectives are useless.

V. V. Anderson.

New York City.

Our Nervous Friends. By Robert S. Carroll, M.D. New York: The Macmillan Company, 1919. 258 p.

The author has already made several contributions dealing with intimate lessons gleaned from his patients, so that others might benefit by his store of knowledge. This is another small book apparently intended for lay consumption, illustrating a previous work, *The Mastery of Nervousness.*

There are twenty-three brief chapters in the make-up of the book, each written in semi-fiction fashion, portraying the lives of those addicted to so-called "nervousness." The separate chapters deal with individual cases from the author's experience. The narrative form, combined with the fact that the author is dealing with real life histories, makes a human appeal that tends to leave a clearer impression on one's memory than one gets from the books of other authors along similar lines.

The histories and clinical symptoms are readily recognized classical types, for the most part psychoneuroses and other individual personality difficulties commonly found.

The title of the book could fittingly be *Lessons in Right Living,* for most of the chapters deal with a conditioned situation and point out a moral as understood by the author. Without personal knowledge of Dr. Carroll's work, one can see from his book that he has a firm belief that metabolism, as related to diet and the digestive organs, has a most important place as an etiologic factor in these nervous states. On properly regulated work and the "omnipotence of the spiritual" he also lays much stress in making readjustments in his patients. In one chapter (XIX) Christian Science is advised. A few cases are cited in which personality situations are handled in a plausible fashion, yet in reading the book one looks forward to some contact with the more complex demands of life and is rather disappointed that more of the fundamental phases of the instinctive life are not displayed in what is considered a very fertile field which modern mental medicine has established as worthy of consideration.

This great host of "nervous friends" are always with us. They need to be better understood and better treated than they are at present. The author's patients undoubtedly have the benefit of his understanding sympathy and the application of common-sense, everyday principles in management. We should have more of this educational material from those who are successfully treating this class of patients. This book should serve a useful purpose to the average physician and the laity. To the neuropsychiatrist it adds little that is new in his work.

Ralph P. Truitt.

Chicago, Illinois.

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NOTES AND COMMENTS

Colorado

The new home and training school for mental defectives, at Grand Junction, which is a branch of the institution located at Ridge, will soon be opened. There are about 300 applications for admission to this institution, which was authorized by the 1919 legislature.

Delaware

The first new building for the Delaware School for Feebleminded is now nearing completion. It will accommodate 50 children. In addition, there are three farm buildings on the property which will be put in a proper state of repair. This institution was authorized by the 1917 legislature, which made an initial appropriation and created the Delaware Commission for the Feebleminded.

Florida

Over $200,000 was granted the Florida State Hospital by the 1919 legislature for additional land, new construction, and improvements.

Illinois

A new wage schedule has been put into effect which grants a 15 per cent increase to the employees of the state hospitals and charitable institutions.

Louisiana

A law authorizing the parish school boards to organize and maintain special classes or schools for mentally or morally deficient children was enacted by the 1920 legislature. Parents or guardians of children coming under this act must enforce regular attendance of their children or wards under penalty of a fine or imprisonment or both. Truancy is to be considered as delinquency and reported to the juvenile court, to be dealt with as determined by the judge of that court. The State Board of Education is authorized to aid in the support of these classes or schools out of any available funds at its disposal. Courses of study are to be approved by the State Board of Education.

House Bill 313, providing for admission to the new State Colony and Training School, and House Bill 315, amending the law establishing this institution, which were summarized in the July number of

MENTAL HYGIENE, were enacted by the Louisiana legislature and approved by the governor on July 7.

Massachusetts

A new schedule of wages for officers and employees of the institutions under the Department of Mental Diseases was authorized by the 1920 legislature. This schedule, which affects particularly the ward, administrative, and farm services, became effective June 1, 1920.

Michigan

The employees of the state hospitals have recently been granted an increase of wages.

Nebraska

A reception hospital will be constructed in the near future at the state hospital for mental diseases, at Hastings.

New York

A hospital for the care and treatment of discharged soldiers, sailors, and marines suffering from mental diseases, who entered service from this state, has been authorized. This hospital is to be known as the New York Military Hospital. It is to provide for 1,000 patients, to be located on Long Island, and to cost $3,000,000.

A commission, appointed by the governor and consisting of the state architect, the state comptroller, the attorney general, a representative of labor, and a member of the medical profession, is authorized to make arrangements with proper authorities of the United States whereby the state agrees to construct such hospital and lease it to the United States for a term not exceeding ten years at an annual rental of not less than one-tenth of the total cost. The United States is to equip and maintain the hospital.

On account of the emergency that is recognized, the commission is relieved from complying with the state finance law, the public-buildings law, the labor law, and the civil-service law in proceeding with the construction, in order that the hospital may be completed as early as possible.

THE MARION NATIONAL SANATORIUM

Immediately after the Civil War, Congress established the National Home for Disabled Volunteer Soldiers. One by one "branches" were established until ten existed, widely scattered between Togus, Maine, and Pasadena, California. Into these homes there has flowed,

during the fifty-five years since the first one was established, a number of veterans equal to almost one-tenth of all those who served in the Northern army during the war. Many veterans received comfort and shelter during temporary periods of stress, while others spent the greater part of their lives in these homes. The high tide was reached in 1905, and since that time, with the falling rate of admissions and constantly increasing inroads made by death, the population has decreased until a year ago nearly half the 25,000 beds in the ten "branches" were vacant.

Last winter when the urgent need of more hospital facilities for the disabled veterans of the World War was engaging the attention of Congress, the Board of Managers of the National Home for Disabled Volunteer Soldiers, which includes in its membership the President of the United States, the Chief Justice of the Supreme Court, and the Secretary of War, called the attention of Congress to the fact that it had available in the various branch homes some thousands of beds, that from the very nature of the plants, they were capable of extension to practically any limit, and that units could be added as needed. The reasonableness of this proposition was at once apparent to Congress, and in the Sundry Civil Bill provision was made for the use of the various branches of the N. H. D. V. S. for the care of beneficiaries of the Bureau of War Risk Insurance.

After this legislation was passed, the Board of Managers took the proposition up with the Director, Bureau of War Risk Insurance, and in these conferences it became apparent that the most urgent need was for additional facilities for the hospitalization of World War veterans suffering from tuberculosis and mental disorders. To meet this need the Board of Managers of the N. H. D. V. S. has set aside two of the branch homes for conversion into sanatoriums for these two classes of patients. Committees composed of eminent men in the two lines of medical treatment referred to above visited various branch homes and reported to the Board that the Mountain Branch at Johnson City, Tennessee, was the most suitable for the treatment of tuberculosis, and the one at Marion, Indiana, for the treatment of neuropsychiatric disorders. Acting upon these reports, the board accordingly set aside the two branch homes indicated above and have arranged for their conversion into sanatoriums, one for tuberculosis and the other for mental disorders.

The National Tuberculosis Association and the National Committee for Mental Hygiene volunteered their services in an advisory capacity to the Bureau of War Risk Insurance and the Board of Managers of the N. H. D. V. S. in the establishment of these new hospitals.

The branch at Marion has officially been designated as the Marion

National Sanatorium, and it is hoped that alterations now under way will permit the reception of 300 patients early in November. As rapidly as possible further alterations are to be pushed, so that early in 1921 the capacity of 1,000 will be reached and by the end of the year the full capacity of 1,200. It would be difficult to find an existing institution more admirably adapted to serve as a great psychiatric hospital than the beautiful branch at Marion. Constructed on the cottage plan, with comfortable detached buildings of moderate size, set in a fine park of trees and lawns, this institution has all the general facilities needed for the care of a thousand patients, together with the administrative and domestic services and provisions for a large personnel of physicians, nurses, and others. In a preliminary report to the board of managers, the advisory committee appointed by the National Committee for Mental Hygiene recommended that the proposed hospital be designed for the most intensive treatment of mental disorders and that in no part of it should mere custody of patients find a place. The detailed plan that they presented was based upon a conception of a hospital for the treatment of mental diseases that would be a hospital throughout, so arranged that every patient, whether acute or chronic, could receive at all times the particular treatment which he required to promote his recovery or to stay the progress of his disease.

Naturally, an institution designed originally for an entirely different purpose required extensive alterations to fit it for such a task as that laid down. With the assistance of the Hon. Lewis F. Pilcher, State Architect of New York, plans have been made for remodeling existing buildings so as to provide four distinct services: Diagnostic, Educational, Continued Treatment, and Convalescent. The arrangement of the plant permits each of these services to be self-contained in a different portion of the institution.

The Diagnostic Service includes a reception hospital of 70 beds, with a pavilion of 24 beds for disturbed cases, a general medical and surgical hospital of 70 beds, and a diagnostic clinic, complete to the last detail, for the study of all problems in surgery, internal medicine, and the medical specialties that the cases received may be expected to present. Attached to this group is a medical center which will contain offices for the scientific staff, the medical library, conference rooms, and a complete laboratory equipped to do research work in neuropathology as well as in general pathology, serology, and physiological chemistry.

The Educational Service consists of 6 cottages accommodating 60 patients each. In this group education will be taken, in its broadest sense, to include all kinds of training required for the resumption of

social life, whether brought about through therapeutic or vocational occupation, physical culture, or any other means that can be brought to bear in securing social adaptability.

The Continued Treatment Service of 175 beds, in a group of 4 detached cottages, is for those patients who fail to make progress enough to justify their retention in the Educational Service and and for whom nursing and individual treatment will very largely take the place of measures applicable to the others. From a survey that has been made of 574 war-risk patients in New York State hospitals, it is evident that this group is yet small. The extent to which it grows will depend in a very large degree upon the success of treatment administered, and the medical staff of the Marion National Sanatorium have set themselves the task of keeping down the size of this group by every possible means. When funds are available for new buildings, an entirely new reception hospital, a farm colony, tuberculosis cottages, and a small isolation hospital will be provided.

Even such a beautiful and efficient hospital as that into which the Marion National Sanatorium is being rapidly converted would be of little real value without a highly trained personnel, each specially fitted to perform his part of the work of solving the difficult problems that the mental diseases of the war have created. Realizing this, the board of managers has authorized a liberal allowance for physicians, nurses, and occupation- and physio-therapy aids. The schedule of salaries of physicians follows rather closely the pay and allowances of officers in the army. The superintendent and medical director is to receive the compensation of a colonel in the army who has had fifteen years of service, the clinical director that of a lieutenant colonel with ten years of service, senior physicians that of a major with five years of service, and assistant physicians that of captain. In addition all physicians will receive heated and lighted quarters, furnished except for china, bedding, linen, silver, and kitchen ware. Physicians, except internes, will not receive maintenance. Medical and dental internes will receive $1,200 and full maintenance. The salaries of nurses range from $2,400 for the director of nurses to $1,080 for ward nurses, all with maintenance. Salaries of hydrotherapy, occupational-therapy, and physio-therapy aids and attendants are on the same scale. The laboratory, which is the core of any medical institution conducted along scientific lines, has not been neglected, and a fund of $25,000 a year has been set aside for research into the special psychiatric problems presented by ex-service men.

A corps of sixty nurses has been authorized for the institution when running at its full capacity, including a director of nurses and principal of training school, an assistant director of nurses and as-

sistant principal of training school, eight supervising nurses, and fifty-two ward nurses. Although the absence of women and children makes it impossible to maintain a full training course for the degree of R.N., a postgraduate course in psychiatric nursing will be established and affiliations made with general hospitals in adjoining states, so that those who desire to secure training in mental nursing during their course of instruction will have an opportunity. The occupation- and physio-therapy department will also have facilities for training, and in the social-service department probationers will be received for practical training in psychiatric social work.

Until alterations are completed, patients will have to be selected and those presenting the graver conduct disorders cannot be received, but when these changes are completed, the only qualifications for admission will be that the applicant shall be a veteran of the World War, a beneficiary of the Bureau of Work Risk Insurance, and suffering from a mental disorder. In all cases the patients become members of the N. H. D. V. S., and it is hoped that by far the largest majority will always remain in the hospital upon a purely voluntary status. The sanatorium will not be a military institution, although its officers and other personnel will be almost entirely selected from those who served in neuropsychiatric work during the war, but the semi-military features that have helped to make these homes attractive and picturesque will be retained. Those in charge of the establishment of the new hospital are sparing no pains to create an institution in which the atmosphere will be that of hope and recovery. The youth and physical activity of the patients is recognized in the plans being made for diversion, occupation, the systematic cultivation of athletics, and physical training. Every possible occupation that can be used to arouse the interest and promote the recovery of the patients will be employed, and as soon as complete or partial restoration seems to be in sight, a strongly vocational trend will be given to all the activities previously carried on as therapeutic measures.

The formal establishment of this new hospital creates a new agency for the care of ex-service men suffering from the most severe and in some ways the most distressing of all the misfortunes that came to the men in military service. It is certain that during the next few years it will bring recovery and restoration to home and friends to several thousand such patients, but it is not unlikely that, in the end, the greatest service rendered by this institution will be the influence it will exert over others by maintaining as high standards of scientific treatment for those whose treatment must continue over a period of many months or years as for those who are more fortunate and have transient mental disorders. In this it will represent an unique medical

enterprise, combining in one institution all the advantages of treatment in a psychopathic hospital and, by using the same highly trained personnel, maintaining standards of treatment for those requiring long continued treatment that are impossible in the public institutions for the indigent insane throughout the country which have to carry on their work with much more limited resources and with the heavy handicap of a background of hundreds of uncured patients remaining from an earlier period in their existence.

Annual Meeting of the Canadian National Committee for Mental Hygiene

The Second Annual Meeting of the Canadian National Committee for Mental Hygiene was held in Vancouver, British Columbia, on June 22, 1920. Dr. Charles F. Martin, president of the committee, in his address outlined the work that had been accomplished by the committee during the year, mentioning particularly the mental-hygiene surveys conducted in British Columbia and Saskatchewan. Emphasizing the fact that the success of the mental-hygiene movement depended largely upon the training of medical students in the diagnosis and treatment of mental abnormality, Dr. Martin stated that the chief work of the committee must necessarily be directed toward the securing of such training for Canada's physicians. Reports were read by Dr. C. K. Clark, Medical Director, Dr. Gordon S. Mundie, Associate Medical Director, and Dr. C. M. Hincks, Associate Medical Director and Secretary. Of especial interest in Dr. Hincks' report was his account of the committee's activities in the field of industrial psychology. In entering this field, it was thought best for various reasons to begin with a study of juvenile labor. Consequently, a public-school survey is being conducted in Toronto, under the directorship of Dr. E. A. Bott, to ascertain such facts as the following: (1) the percentage of retardation among children who leave the public school to go to work; (2) the reason children under sixteen years of age leave school for industry; (3) the history of the past two years of the individual life of the child. It is hoped that this study not only will result in the evolution of a school program that will be better suited to the needs of backward children, but may eventually be extended to include the whole educational system, with a view to providing a more adequate preparation for citizenship.

The following officers were elected for the ensuing year:

Patron: His Excellency the Duke of Devonshire, Governor General of Canada.

Patroness: Her Excellency the Duchess of Devonshire.

President: Dr. Charles F. Martin.

Vice-presidents: Sir Arthur Currie, Sir Robert Falconer, Sir Lomer Gouin, Sir Vincent Meredith, Sir William Price, and Lord Shaughnessy.

Treasurer: Sir George Burn.

Associate Treasurer: Mr. George H. Ross.

Executive Committee: Dr. C. K. Russel, Chairman, Dr. E. A. Bott, Prof. J. A. Dale, Dr. A. H. Desloges, Dr. C. E. Doherty, Dr. J. Halpenny, Dr. C. J. O. Hastings, Dr. W. H. Hattie, Mr. Vincent Massey, President W. C. Murray, Dr. J. D. Pagé, Dr. C. A. Porteous, Prof. D. G. Revell, Hon. Dr. W. F. Roberts, Dr. E. W. Ryan, Prof. Peter Sandiford, and Rev. W. H. Vance.

Finance Committee: Mr. D. A. Dunlap, Chairman, Sir George Burn, Mr. J. B. Holden, and Mr. George H. Ross.

Subcommittee on Educational and Industrial Psychology: Mrs. D. A. Dunlap, Lady Eaton, Miss Helen Reid, Mrs. H. D. Warren, Dr. E. A. Bott, Prof. J. D. Dale, and Rev. W. H. Vance.

Executive Officers: Dr. C. K. Clarke, Medical Director; Dr. Gordon S. Mundie, Associate Medical Director; and Dr. C. M. Hincks, Associate Medical Director and Secretary.

The following members were added to the committee: Sir Arthur Currie, Montreal; Dr. Malcolm T. MacEachern, Vancouver; Dr. J. W. MacNeill, Battleford, Saskatchewan; Dr. A. D. Campbell, Battleford, Saskatchewan; Judge H. S. Mott, Toronto; Dr. George Anderson, Toronto; Mr. P. C. Larkin, Toronto.

Cape Province Society for Mental Hygiene

A deputation from the Cape Province (South Africa) Society for Mental Hygiene, to which is affiliated the Cape Town Committee for Care of Mental Defectives, has waited upon the Minister of Education, asking him to submit to the government the resolutions passed at the Child Welfare Conference in 1919. These resolutions were that the Conference "press upon the government the urgent need of immediate adequate provision to be made for the care, education, and training of the feebleminded, including the establishment of suitable institutions and the appointment of medical experts who shall furnish the authorities with reports on the different schools, etc." The deputation was informed by the Minister of Education that the government had decided to open an institution at the Alexandra Hospital for Women and another at Frankenwald for girls.

It has recently been decided by the Committee of the Duxhurst Home, which has treated inebriates, to close that part of their work and to devote the home to care of feebleminded girls of the better

class. These will be paying patients. Formerly these patients have been sent to Europe through lack of a suitable institution in South Africa, at an estimated annual cost of from £15,000 to £20,000.

A Society for the Study of Mental Hygiene and the Amelioration of the Lot of the Mentally Deficient has been organized in Johannesburg with Dr. Marius Moll as its chairman. The society plans to establish a home for the mentally defective.

Circulars have been issued by the Cape Province Society on the lines suggested by the Permanent Committee of the (1919) Child Welfare Conference. These propose two plans: (1) for the formation of local societies for mental hygiene, (2) for the formation of a National Council for Mental Hygiene. These plans were to be discussed at the Child Welfare Conference held in Bloemfontein in September.

Ellisville, Jones County, Mississippi

Five hundred citizens of Ellisville and Jones County, Mississippi, recently subscribed $200,000 to be added to the $100,000 appropriated by the Mississippi legislature for the establishment of the Mississippi School for the Mentally Defective. The subscriptions were in the form of notes to be used in underwriting the needed loan. The funds subscribed will later be repaid by the city of Ellisville and Jones County. The success of the movement was largely due to the enthusiasm of the Hon. J. T. Taylor, Mayor of Ellisville.

The Fifteenth International Congress Against Alcoholism

The Fifteenth International Congress Against Alcoholism met in Washington, D. C., September 21-26, 1920. The decision to hold this Congress in the United States was made in 1913, when the Fourteenth Congress was held in Milan, Italy. The United States Government thereupon authorized the holding of the Congress under official auspices, with a formal invitation to foreign governments to participate and an appropriation to meet the necessary expenses. The plan then was to hold the next Congress in 1915, but the World War intervened, and it was not until the spring of 1920 that the American Executive Committee, appointed by the Department of State in 1914 to have charge of the arrangements for the Congress, was able to take up again its work of preparation.

In connection with the Congress, there was an exhibition of the materials and methods that are used throughout the world in the campaign against alcohol. It included scientific models, journals and

literature and charts and posters in many languages and from many countries, historic documents, etc. A number of national and international organizations, such as the World League Against Alcoholism, the World Prohibition Federation, the Women's Christian Temperance Union, and the Scientific Temperance Federation, held meetings and conferences at Washington during the period of the Congress at hours that did not conflict with its regular sessions.

Several of the papers on the program were of especial interest to students of mental hygiene, among them the following: *Nervous and Mental Diseases in Their Relation to Alcoholism,* by Dr. Paul-Maurice Legrain, Paris; *Latest Scientific Investigation in America of the Action of Alcohol on the Brain, the Nervous System, and Heredity,* by Dr. Charles R. Stockard, Cornell University; *Wine as a Cause of Alcoholism,* by Prof. Dr. P. Amaldi, Director of the Hospital for the Insane, Florence, Italy; and *Prohibition in the United States—Analysis of Results,* by Hon. Bird S. Coler, Commissioner of Public Welfare, New York City.

A feature of interest in connection with the Congress was the fact that it was the first international congress against alcoholism that had ever had an opportunity to meet in a country in which traffic in alcoholic liquor is prohibited by law.

American Institute of Criminal Law and Criminology

The Twelfth Annual Meeting of the American Institute of Criminal Law and Criminology was held in Indianapolis, Indiana, September 16 to 18. Professor Edwin R. Keedy, of the University of Pennsylvania, presented a report of the Committee on Insanity and Criminal Responsibility. Among the papers read at the meeting was one by Dr. H. H. Goddard, Director of the Bureau of Juvenile Research, Columbus, Ohio, *In the Light of Recent Developments, What Should Be Our Policy in Dealing with the Delinquent—Juvenile and Adult?* and another by Dr. Herman M. Adler, State Criminologist, Chicago, *The Criminologist and the Courts, Illustrative Cases.* Dr. Horatio Pollock, Statistician for the State Hospital Commission, Albany, New York, presented a report of the Committee on Criminal Statistics.

Correction

The article by Dr. S. I. Schwab, *Influence of War upon Concepts of Mental Diseases and Neuroses,* in the July number of Mental Hygiene was reprinted through the courtesy of *Modern Medicine.* It was incorrectly credited to *The Modern Hospital.*

Insane Persons in Jail

Editorial, *Indianapolis News*

Dr. Walter A. Jillson, who has charge of the Neuropsychiatric Division of the Public Health Service for the Seventh District, condemns the laws of Indiana for the reason that a former British soldier was confined in a northwestern Indiana jail because he was insane. No provision was made for his transfer to an insane hospital. The board of state charities demanded action. This was promised, but nothing was done. The case becomes one of more importance for the reason that the soldier is a British subject. The Public Health Service has agreed to take care of former members of the allied armies who become insane in this country. The federal government may now have to make an apology to Great Britain.

Jails were instituted for the temporary detention of men and women who are arrested on charges of having committed crimes or for the punishment of those who have been convicted of crimes. It sometimes becomes necessary to place a dangerously insane person in jail for a short time because no other place may be available for his safe keeping. There is no excuse, however, for keeping insane patients in jail for an indefinite period. There would be just as much reason for placing people in jail because they were afflicted with tuberculosis or typhoid fever as there would be because they are insane.

Probably this Englishman was not entitled to an insane hospital because he was not a legal resident of the community. That may be compliance with the law, but the law is too exclusive. For several years a campaign has been under way to prevent the detention of insane persons in jail. Such cases as that of the former English soldier serve to emphasize the need for a change.

Division Psychiatrists of the Federal Board for Vocational Education

The Division of Rehabilitation of the Federal Board for Vocational Education is appointing in each of the fourteen geographical districts a psychiatrist who will serve as psychiatrist to the district. The duties of the district psychiatrist are as follows:

1. To assist the eligibility officer in determining eligibility;
2. To rate neuropsychiatric applicants for training;
3. To determine feasibility of training in each instance;
4. To assist the advisement section in deciding the particular sort of training indicated;
5. To advise as to diversion and recreation for neuropsychiatric trainees;

6. To advise in the follow-up work for the neuropsychiatric trainees;

7. In so far as possible, to maintain contact with such trainees, and assist in adjusting any conflicts that may occur during training;

8. To examine such trainees as present themselves for this purpose at the district vocational office, if it seems expedient to have him make the examinations personally rather than have them done by the district supervisor's office.

In view of the fact that a large part of the information upon which he must base his opinion as to the rating and advisement comes directly from the psychiatric department of the district supervisor's office, it is axiomatic that it is absolutely essential that he shall establish perfect liaison with the psychiatrist of that office, in order that this material shall not only be as complete as possible, but shall also be available at any and all times.

As his function is to determine feasibility of training and in a general way the kind of training indicated in the individual case, it becomes equally apparent that perfect liaison should be established between the psychiatrist and the section of advisement and training of the district vocational office. To this end it would seem feasible that a well-qualified advisement man and the psychiatrist work together, have desks immediately contiguous one to the other, and never at different times and different places determine the advisement in a neuropsychiatric case.

It will be found that the prospective neuropsychiatric trainees will under this plan divide themselves into these several classes:

Not Feasible

1. A class that requires intra-mural treatment, and in which, therefore, training is not feasible.

2. A class of trainees which require active treatment and for that reason are not trainable, or because the specific disease with which they are affected is an essentially progressive one and will make training not feasible.

Feasible

3. A class that may be trained under the usual conditions after the proper selection of vocation has been made by a qualified officer. This class will compose much the larger group under discussion.

4. A class in whom training is feasible only in a properly selected vocation under special supervision.

The psychiatrist will understand that the fact of his having placed a trainee in either of the first two classes enumerated above does not close the man's case, but that it shall be subject to revision at any time, and his classification shall again be determined without prejudice on a basis of the facts furnished at this revision.

He will be able to assist the advisement section in determining the proper vocation for the large group in Class 3, and they may be immediately put into training.

Class 4 will tax the ingenuity and skill of both the psychiatrist and the training and advisement section to the utmost, but it is believed that quite a large percentage of this class can be handled under present conditions, with the skillful guidance in the selection of vocation and placement in training that will accrue from the perfect liaison established between the psychiatrist and the advisement and training section. It will be necessary to provide special arrangements for the handling and training of the remainder of this group, and at the present time arrangements are being made which, it is believed, will satisfactorily solve this difficult problem.

Each case will be decided on its own merits upon a basis of the man's eligibility and feasibility considered in the light of "how he has acted in the past" and "how he acts at present," and without undue regard to the diagnosis or any preconceived ideas the psychiatrist may have. Wherever there is a reasonable doubt as to the feasibility of training, the prospective trainee must be given the benefit of the doubt.

The services of at least one neuropsychiatric social worker will be provided, as soon as it can be arranged, to assist the psychiatrist in maintaining contact, in doing the necessary follow-up work, in adjusting difficulties and conflicts that may arise during training, in obtaining histories including home environment, and in any other work that may be indicated.

Appreciative of Offered Advantages

Editorial, *The New York Times*

Proof that the [New York] State Department of Health was well advised or inspired when it planned the holding in rural counties of what it calls "group consultation clinics" is given by the fact that the first of them, just held in Orange County, commanded the interest and presence of both physicians and patients in large numbers.

The physicians came to see in actual application the new devices for accurate diagnosis that hitherto have been available only in the larger cities, and the patients, either on their own initiative or the advice of the local practitioners, arrived from many miles around in order to take advantage of an opportunity hitherto denied to many of them because journeys to the larger medical centers are expensive.

No trace of jealousy on the one hand or of distrust on the other marked the welcome of the visitors—good evidence that some part of advanced medical knowledge has spread far, outside of the medical profession as well as in it, and that the too prevalent resort to the

worthless nostrums still so extensively advertised in the country papers may not be as much due as has been supposed to ignorance and obstinacy.

Clinics like the one in Goshen are to be held as soon as possible in the other rural counties that are asking for them eagerly, and thus there should be produced an appreciable improvement in general health conditions throughout the state.

Training Counts

In a recent number of the *Hospital Social Service Exchange* of the American Red Cross, Department of Health Service, we find the following interesting item. It shows that training counts. The patient apparently had nothing wrong with his stomach, but why did the social worker have to point out that there might be something wrong with his mind?

"Not long ago there came to our office a patient who had been discharged a few hours previously. He had been in one of the medical wards, and the doctor felt that his condition needed no further treatment. During our conversation with the boy, we learned that he was bound for nowhere in particular. He had, before his entrance into the hospital, lived alternately with several sisters, but with each of them there had been some misunderstanding, and he no longer felt welcome in their homes. His father was dead and his mother, he stated, was in our city hospital (for mental cases). His statements were hazy, his manner was hesitating, and his general attitude suggested a mental abnormality. We communicated immediately with the doctor who had discharged him and found that no mental examination had been made because the man came presumably for a stomach disorder. It was finally agreed that he should remain in the hospital overnight while we made an investigation to find out what the real situation was. Investigation proved that the boy had a mother who had been an inmate of the city sanitarium for years and that the sisters were unwilling to have the boy with them because of his queer actions. For a period previous to his entrance into the hospital he had worked in a factory, and because his work was merely mechanical and required no brain effort, he got along very well. However, the sister stated that he never could find his way home from his work, but always wandered about the streets before he finally reached home late in the evening. By and by his foreman set him at another kind of work which required more initiative. The result was that the boy was discharged because he was incapable of holding the new job. The day after our investigation the boy was transferred from the medical ward to the neuropsychopathic ward for observation, and his latest diagnosis is that of dementia praecox."

Social Unrest and Delinquency

Fifty-third Annual Report of the New York State Board of Charities

Before the great cataclysm of the World War took place, experts had formulated ideas concerning the types of delinquents rather clearly into a few groups: namely, delinquency due to gross mental defect; delinquency due to slight mental defect (moronism) associated with affective deviation; delinquency due to constitutional psychopathic states associated with an inadequate personality, tendency to pathological lying, wanderlust, and other allied traits not useful to society; delinquency due to definite psychoses either of a constitutional type or organic in nature; delinquency due to extraordinary environmental reactions and occurring in presumably normal mentality. It was felt in pre-war days that the problem of caring for delinquent types could be fairly well met by the extension of mental clinics which would separate the various types known to exist and leave the residue of so-called normal individuals largely to the care of a modified parole system, after the abnormal mental types had been placed in institutions suited to their care, whereby much of the old horror of prison life would be abolished, with much better results as to the chances for the rehabilitation of the individual.

The World War, with its consequent upsetting of all ordinary balances in social and commercial life, flame-colored by the extraordinary emotional swings of the whole human race in connection with the death and devastation produced, has demonstrated that delinquency among the so-called normal type in the groups enumerated above is a thing which depends upon many factors, some but dimly recognized in the past, all of which affect the individual. Some of these traits reach back into heredity; others depend upon environment in childhood and general training; others are influenced by the constitutional peculiarity of the individual's character which may show extraordinary emotional traits, particularly in the direction of overvaluation of ideas, easy suggestibility, and the like. Individuals of this latter group in ordinary times might have remained staid and plodding citizens in a simple and unchanging environment, but ambitions and long submerged wishes were able to find an outlet through the excitement of the war or through extraordinary commercial situations arising during the course of the war, including unexpectedly high wages and vastly increased ability to satisfy personal whims and cravings. Under such circumstances many persons developed a peculiar attitude of mind quite at variance with former concepts of their station in life and the possibilities of their community. As a result we read of waves of crime which have swept over the world,

orgies of dissipation, and in particular an increase in crimes of acquisitiveness as witnessed in the tremendous increase in automobile thefts, silk stealing, and the like.

Delinquency, then, must be looked upon not only as the reaction of an individual possibly of an abnormal type, but also as the reaction of an individual in any of these types in relation to his environment when the environment itself shows extraordinary variation from what might be expected.

The consideration of these things demonstrates more forcibly than ever before how the whole future of the problem of delinquency depends first upon adequate diagnosis of existing mental or physical defect, the correction of these defects so far as possible, and the training of the individual in a scholastic and vocational way, and finally the placing out of the individual under supervision in the community in a sphere to which he will be suited by reason of the foregoing diagnosis and specialized training. It is important that institutions be adequately manned by a personnel having insight into these needs who will further assist in the rehabilitation of social liabilities under their care through an adequate graded scholastic and vocational system, and finally through a modern parole system which by social service will reduce environmental stress to the minimum.

Psychopathic states of all kinds represent abnormal mental reactions and a certain number of such individuals will always be found in any institution caring for delinquents. It is therefore a matter of administrative efficiency as well as of scientific value that such institutions have at least one ward equipped for the care of psychopathic cases wherein they may be treated by approved methods, including hydrotherapy and continuous baths. As is well known, many of the psychopathic upsets in such individuals are quite transitory in nature and the ability of each institution to care for its disturbed cases from time to time will prevent an undue number of transfers. This plan implies that cases showing actual psychoses or mental defect of such a character as to render the individual unable adequately to care for himself should be cared for in hospitals and institutions built and equipped for the care and treatment of such cases.

It is probably true that the human race as at present constituted requires a certain amount of repression and fear of consequences in order to prevent those less highly endowed from becoming antisocial and a nuisance. Therefore, just laws must always be the rule of the state. But we shall have taken a great step in advance when, in arranging for the care of crass delinquency as it now appears in our courts, we provide for its proper determination, care, and treatment rather than for punitive measures alone which are as old as the world and which to-day are as unsatisfactory as they always have been.

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